GEORGIA CHILD FATALITY REVIEW PANEL

Annual Report
Calendar Year 2002

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GEORGIA CHILD FATALITY REVIEW PANEL

MISSION

To serve Georgia's children by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse cases and child fatality investigations, and monitoring the implementation and impact of the statewide child abuse prevention plan in order to prevent and reduce incidents of child abuse and fatalities in the State.

Acknowledgements

The Georgia Child Fatality Review Panel wishes to acknowledge those whose enormous commitment, dedication, and unwavering support to child fatality review have made this report possible. These include:

- John T. Carter, Ph.D., Jill Davis, M.P.H., Tushar Shah, M.B.B.S., and associates of the Epidemiology Department of Emory University, Rollins School of Public Health
- Mike Lavoie, Director of the Office of Vital Records
- All the members who served on each of the county child fatality review and child abuse protocol committees
- All the other public/private agencies that have so willingly collaborated with this office and provided support

GEORGIA CHILD FATALITY REVIEW PANEL

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Protection of Children[3]

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Research Data Contractor

Carri Cottengim
Program Manager

The Georgia Child Fatality Review Panel is an appointed body of 16 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data. Two year appointments are made by the Governor except as otherwise noted.

1 Appointed by the Lieutenant Governor
2 Appointed by the Speaker of the House of Representatives
3 Ex-Officio

Georgia Child Fatality Review Panel

"Branching out for Prevention"

November 6, 2003

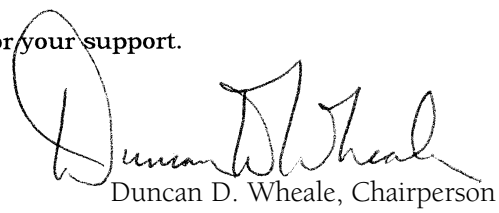
Dear Governor and Members of the Georgia General Assembly,

It is hard to find something positive to discuss when talking about children in Georgia who have died. There are, however, some positive things to report this year. With your help and support, in 2003 we have accomplished the following:

- Realizing the highest rate of compliance by county committees for reviewing child deaths eligible for review (88% for 2002 deaths, compared to 75% for 2001 and 67% for 2000).
- Legislation appointing district attorneys to serve as chairpersons of local committees in their circuits. This will result in more stability and accountability for the process of child fatality review.
- Legislation giving the Superior Court judge on the Panel the authority to issue an order requiring the participation of mandated agencies on local child fatality review committees. Failure to comply would be cause for contempt.
- Legislation giving the Panel the authority to compel the production of documents or the attendance of witnesses pursuant to a subpoena.
- Legislation to add the director of the Division of Mental Health as a member of the Panel. Mental Health representatives already serve on local committees.
- Publishing and distributing a child fatality review protocol manual to all county committee members.
- Instituting an on-line reporting system to assist counties in filing reports electronically.
- A child abuse prevention and child fatality prevention day at the capitol.

With these major changes and improved reporting statistics, we are able to identify the major causes of these deaths and make recommendations to reduce them. The most staggering statistic you will read in this report is that 110 children died from abuse or neglect. We know this number will never be zero, but the members of this Panel will not stop working until it drops substantially. We also focus on other causes and continue working to educate the public on how to prevent unintentional deaths of children.

We welcome your input and thank you for your support.



Duncan D. Wheale, Chairperson
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Georgia Child Fatality Review Panel

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This past year has been one of reflection and introspection. As we examined the efforts of the Panel and child fatality committees across Georgia to safeguard children, our attention was drawn to the long road ahead. But just as importantly, we looked behind us to see the long road already traveled. During the earlier years of child fatality review, many counties refused to review child deaths, basing their refusal on the law being an "unfunded" mandate. Others did not view the process as having a meaningful purpose; therefore their reviews were cursory at best. Compliance rates for reviews statewide were initially low with only 46.5% of eligible deaths being reviewed by counties in 1993.

Over the last ten years, we've seen a slow, but steady increase in the compliance rate. We've learned that child fatality review is a process, and to prevent child deaths, we must purposefully lay the groundwork necessary to achieve the desired goals for each stage of the process. County child fatality review committees must be educated on child deaths in their communities and the state. Training must be provided on conducting structured reviews and ascribing to proven prevention strategies. But most importantly, committees must embrace the idea of being gatekeepers to assure these prevention strategies are implemented in their communities. It is only then that we will begin to see the number of preventable child deaths decline.

The exciting news is that though child fatality review in Georgia has been a work in progress, committees are beginning to act on lessons learned. Many strides have been made at both the State and local levels to facilitate the implementation of practices to reduce the number of preventable child deaths. Staff members have worked hard with local committees to increase the rate of compliance for child deaths reviewed, and we are pleased that in 2002, 88% of child deaths eligible for review (528 of 601) were reviewed by local committees. This represented the highest compliance rate since the inception of child fatality review in Georgia. Examples of local committees' involvement in prevention efforts included:

- Work with a local hotel chain to offer cribs free of charge to parents with infants;
- Collaboration with the media to broadcast and print prevention information to benefit caretakers; and,
- A school system engaging students' help in recognizing and reporting possible signs of suicide observed in classmates and/or friends;
- Another school system provides parents with seasonal/age appropriate injury prevention tips with each (k-12) student's report card and/or progress report.

While realizing that we still have a ways to go in preventing child deaths, we are encouraged that Georgia is well on its' way, and committed to stay the course.

In the words of Former Attorney General, Janet Reno, "We may not be able to save the life of every child, but we can try."

EXECUTIVE SUMMARY

The Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. Information in this report details deaths that were sudden, unexplained and/or unexpected. This information is compiled from reports submitted by local child fatality review (CFR) committees. The Panel is charged with tracking the numbers and causes of child deaths as well as identifying and recommending prevention strategies that could reduce the number of child deaths.

Key Findings

In 2002, 1,795 children died in Georgia. Based on death certificated data, 601 deaths were eligible for review. Child fatality review committees reviewed 528 of those deaths; however, the cause of death listed on death certificates and the cause of death determined by the child fatality review committees sometimes differed.

FATAL CHILD ABUSE/NEGLECT

Department of Family and Children Services (DFCS) reported that 51 children in Georgia died as a result of substantiated abuse or neglect. Those deaths were investigated by DFCS, and did not include deaths handled by law enforcement and the courts without DFCS involvement.

Child fatality review committees determined that 63 child deaths resulted from confirmed abuse/neglect, and 47 child deaths resulted from suspected abuse/neglect. Perpetrators were identified in 65 of the 110 abuse/neglect related deaths, with 50 reviews also indicating the relationship of the perpetrator to the child. Fifty-six percent (56%) of those perpetrators were natural parents. Homicide was the cause of 28 confirmed abuse deaths, and children under the age of 5 accounted for 86% (24) of those homicides.

NATURAL

Death certificate data indicated a total of 1,351 children under the age of 18 died of natural causes (including SIDS). Infants accounted for the vast majority (1,124) of those deaths. The leading causes of infant deaths continued to be congenital anomalies, low birth weight, and prematurity. There were 141 SIDS deaths, which was a 22% increase from the previous year.

Child fatality review committees reviewed 264 deaths from natural causes. One hundred fifty-two (152) of those deaths were SIDS/SUID. (SUID - Sudden Unexplained Infant Death - is a term used for a death that appears to be SIDS, but has other factors that *could* have contributed to the death.) Committees are required to review all SIDS deaths, and medical deaths that are unexpected or unattended by a physician.

INJURIES

Death certificate data listed 416 deaths to have resulted from known injuries, but 7 of those deaths listed an unknown intent. An additional 28 deaths listed an unknown cause.

UNINTENTIONAL INJURIES

Death certificate data indicated that 61% (372) of deaths in children ages 1 – 17 resulted from injuries (infant deaths [1,188], were mostly due to natural causes [1,124]). Seventy-eight percent (78%) of all injuries in the 1-17 year age group resulting in death were unintentional. The 3 leading causes of unintentional injury related deaths in all age groups included:

- 192 motor vehicle incidents
- 44 drowning incidents
- 22 fire/burn-related incidents

There was a decrease in the number of all deaths caused by unintentional injuries with the exceptions of drowning deaths (10% increase from 2001), and poisoning deaths (remained the same from the previous year). The most marked decrease in deaths from 2001 was suffocation (39%).

Child fatality review committees reviewed 287 deaths determined to have resulted from unintentional injuries. Child fatality review and death certificate data agreed on the 3 leading causes of death related to unintentional injuries (see above).

INTENTIONAL INJURIES

Death certificate data indicated 83 children died from injuries intentionally inflicted by themselves or by others (suicide and homicide). In 2002, there were 58 homicides (a 22% decrease from 2001), and 25 suicides (a 36% decrease).
(*Note: The cause and/or intent of 35 child deaths were listed as undetermined on death certificates.)*

Child fatality review committees reviewed 89 deaths from intentional causes – 64 homicides and 25 suicides. Committees determined additional deaths to have resulted from homicide that were not identified as such on death certificates.

FIREARM DEATHS

Death certificate data indicated firearms were used in 58 child deaths. Thirty-three of those deaths were ruled homicides, 15 suicides, and 9 unintentional. The intent of 1 firearm death was not determined.

Child fatality review committees reviewed 58 firearm related deaths. Eighty-three percent (83%) were intentional (34 homicides and 14 suicides). The type of firearm was identified in 52 of the 58 reviewed firearm related deaths. Handguns were most frequently used (42 of the 52 deaths where type of firearm was identified).

PREVENTABILITY

A primary function of the child fatality review process is to identify those deaths believed to be preventable. The issue of preventability was addressed in 648 of the 655 child deaths reviewed. Child fatality review committees determined that 77% (501) of the 648 identified child deaths were definitely or possibly preventable. Ninety-seven percent (97%) of all reviewed child abuse/neglect deaths were determined to be definitely or possibly preventable.

Agency Involvement/Intervention

Child fatality review committees reported that in 76 (69%) child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. Committees identified 5 instances in which agency intervention could have prevented child abuse/neglect related deaths.

ACCOMPLISHMENTS, RECOMMENDATIONS, AND GOALS OF THE GEORGIA CHILD FATALITY REVIEW PANEL

Accomplishments:

1. Increase of 13 percentage points in county reporting compliance
2. Implemented an on-line reporting system to assist counties with filing child fatality review reports
3. Published and distributed a "Child Fatality Review Policy and Procedures" manual
4. Increase distribution of Panel's Annual Report (from 1000 in year 2001 to 2000 copies in 2002)
5. Co-Sponsored an annual conference with the Department of Family and Children Services and Office of the Child Advocate on serious injuries and child fatalities

Legislative Recommendations:

1. Fully implement recommendations of the Child Protective Service Task Force to improve the state's ability to protect children from child abuse and neglect
2. Fund expansion of home-based family support models that promote and enable appropriate parenting skills for prevention of child abuse and neglect
3. Require fences and gates in public and private swimming pools statewide
4. Require an autopsy, including toxicology studies, for every death of a child under the age of seven with the exception of children who are known to have died of a disease process while attended by a physician. Further, require complete skeletal x-rays (following established pediatric and radiological protocol), of the bodies of children who died before their second birthday
5. Pass a "Child Endangerment Law" to hold adults accountable who knowingly create or allow children to be placed in dangerous situations
6. Provide sufficient funding to the Georgia Child Fatality Review Panel to fulfill statutory requirements
7. Expand funding for mental health services for children, especially those identified as "at risk"
8. Pass legislation strengthening the requirements of Georgia's child restraint law to provide for the use of car seats and booster seats for children under the age of 7

Agency Recommendations:

1. DFCS: The Panel recommends that when a child dies due to parent(s) or caretaker(s) neglect or aggression, efforts be made to visit the surviving children in that home on an ongoing basis to assess their safety and well-being, and enable referrals to appropriate services
2. DFCS: Strengthen risk assessment & safety tools based on recommendations of the Panel's Study Committee
3. Publich Health: Increase efforts of public awareness campaign regarding safe sleeping environments, and include risk factors associated with co-sleeping
4. Coroner & Medical Examiner's Office: The Panel recommends that a death scene investigation be conducted for any child death that is suspicious, unexpected, and/or unexplained. No case should be classified as SIDS unless a death scene investigation and review of the clinical circumstances are completed

Goals:

1. Development of a "Best Practices" manual for county child abuse protocol committees
2. Increase child fatality review committee reporting compliance to 95%
3. Increase the number of child death investigation teams in the state

Child deaths in Georgia, especially those resulting from abuse or neglect, continue to be the focus of the media. In 2002, 1,795 children died in Georgia, which was equivalent to almost 5 deaths per day. Most of those deaths were due to medical causes (1,194), and occurred among infants (967). The remaining deaths, (601) were the main focus of child fatality review committees. (Medical deaths are indicated for review only if unexpected, unexplained, or unattended by a physician.) The purpose of the child fatality review process is to analyze all circumstances of child deaths. This process is critical in identifying prevention strategies that can help reduce needless deaths and improve the well-being of Georgia's future generations.

Information Sources

Child fatality review reports are the primary source of data for this report. Child fatality review (CFR) reports are submitted on deaths that are identified by the county coroner, medical examiner, and/or death certificate information. In addition to unintentional, intentional, and SIDS deaths, the committee may identify other deaths as appropriate for review (e.g., medical deaths unattended by a physician). Child fatality review reports provide details of the cause and circumstance of death, supervision at time of death, prior history of abuse or neglect, perpetrator(s) in child abuse-related deaths, and prior agency involvement. Reports also contain information regarding whether a death might have been prevented and what measures might be taken to lessen the likelihood of a similar death occurring in the future.

The 2002 Vital Records preliminary death certificate file was used to describe all child deaths. This file was also used to identify the subset of deaths that met the criteria for review. The child fatality review file was linked with the death certificate file. The death certificate provides demographic information and states the official cause of death. These two data sources do not always agree on the cause or manner of death. Child fatality review committees determined 92 reviewed child deaths to have resulted from a different cause than that reported on the death certificate.

Of the 1,795 child death certificates filed in 2002, 601 met the criteria requiring review. Child fatality review committees reviewed 528 (88%) of those eligible deaths, in addition to 10 deaths for which no death certificate was issued, and 117 deaths related to medical causes based on death certificate data. Committees identified 67 medical deaths to be unexpected, unexplained, or unattended by a physician, making them eligible for review. A total of 655 deaths were reviewed and are included in Appendix C.2 of this report.

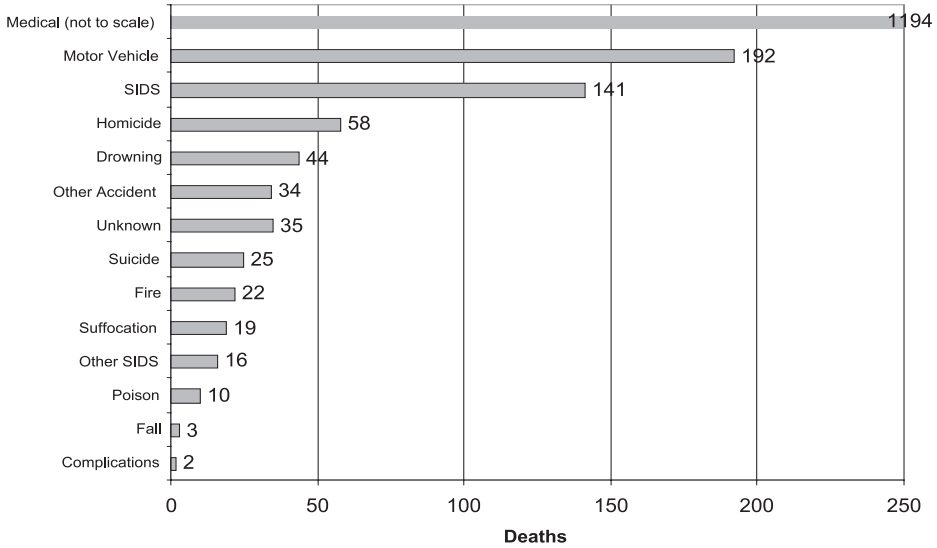
Except as noted, information and figures from CFR reports are designated by the term "Reviewed Deaths". Those include all child deaths reviewed by committees (655) with the exception of deaths determined by committees to be medical(112), for a total of 543. All information presented in the "Trends" section is based on death certificate data.

SUMMARY OF ALL DEATHS

Figure 1 shows the causes of all 1,795 child deaths in Georgia in 2002. Natural causes were responsible for 75% (1,351) of all deaths, with 83% (1,124) of those deaths occurring before age 1.

The term "medical" when used in this report as a cause of death for infants does not include SIDS.

Figure 1. Deaths to Children Under Age 18 in Georgia All Causes based on Death Certificates

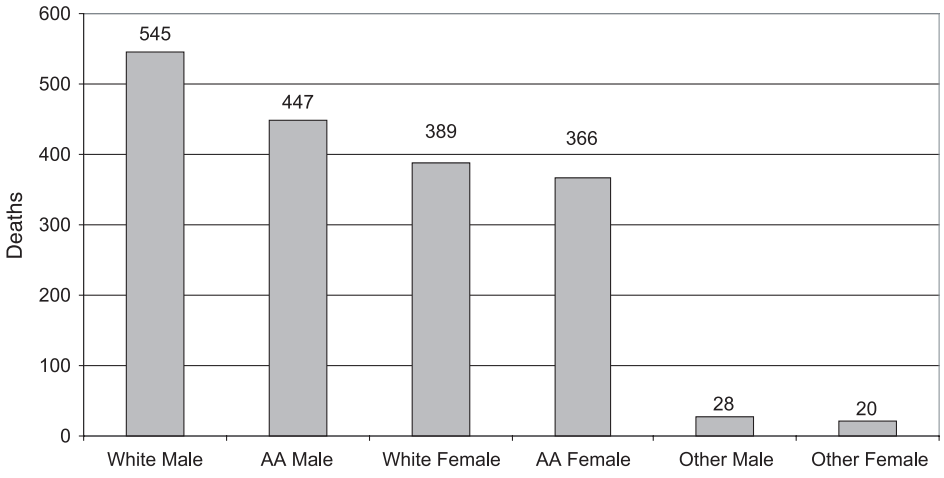


Findings

- The total number of infant/child deaths (1,795) is higher than the average number of child deaths per year (1,747) for the period 1997-2001

- In 2002, deaths from SIDS represented the largest increase (from 116 in 2001 to 141 in 2002). The largest decrease was associated with motor vehicle related deaths (224 in 2001 to 192 in 2002)

Figure 2. Race and Gender of All Child Deaths, 2002

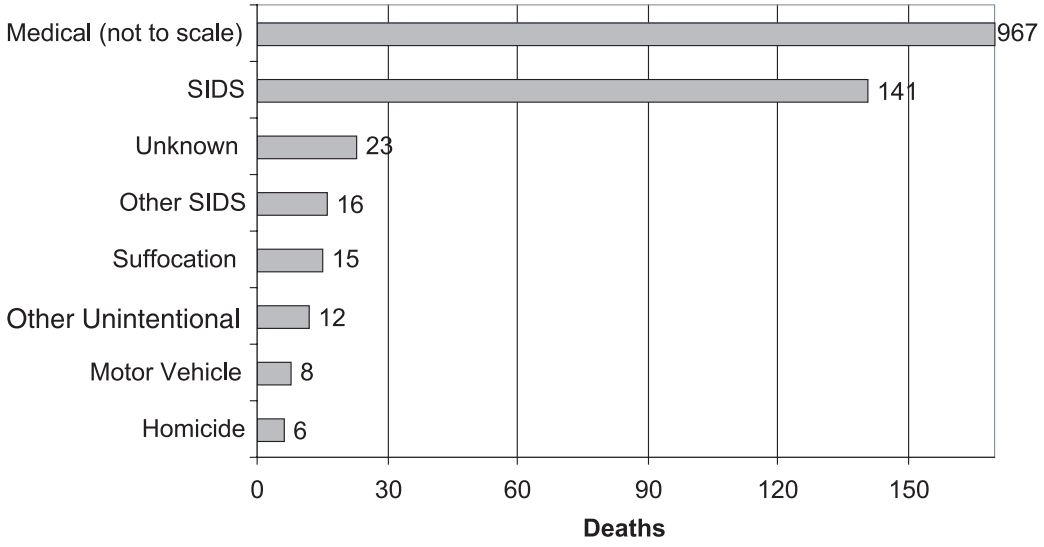


Findings

- African American children make up 35% of the child population; however, their deaths make up 45% of all child deaths

- Although not shown in the figure, there is again an increase in deaths among Hispanic children (from 95 in 2001, to 133 in 2002). This increase is associated with the increase of Hispanic children in the population in Georgia

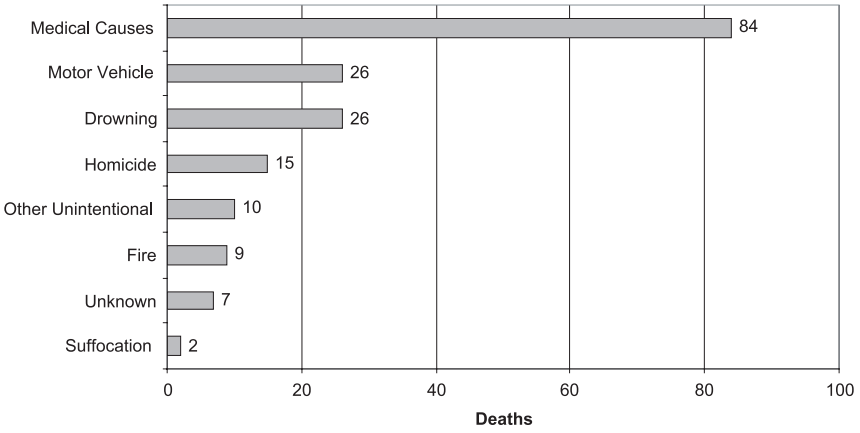
Figure 3. Causes of Death, All Infant Deaths, Georgia, 2002



Findings

- Only 44 infant deaths (4%) resulted from unintentional or intentional injuries
- SIDS deaths are up from 116 in 2001
- Of defined causes, suffocation continued to be the largest single injury-related category

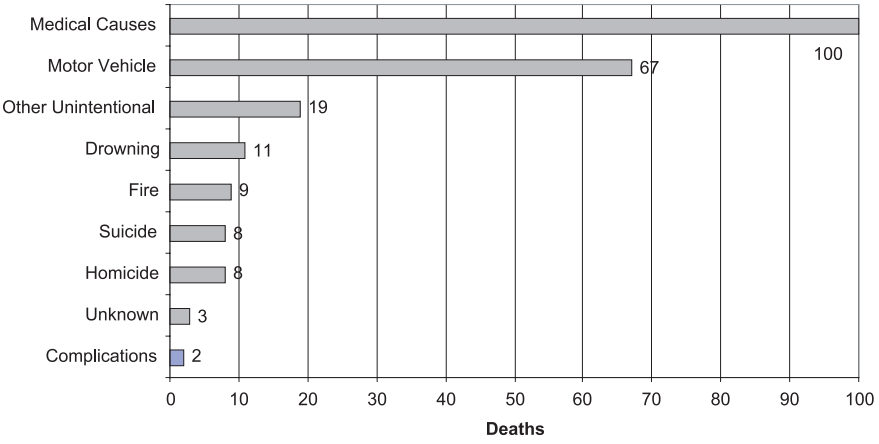
Figure 4. Causes of Death, Children Ages 1 to 4, Georgia, 2002



Findings

- Deaths in this age group decreased (from 203 in 2001 to 179 in 2002)
- Drowning deaths increased from 16 in 2001 to 26 in 2002
- All other causes of death decreased in this age group

Figure 5. Causes of Death, Children Ages 5 to 14, Georgia, 2002



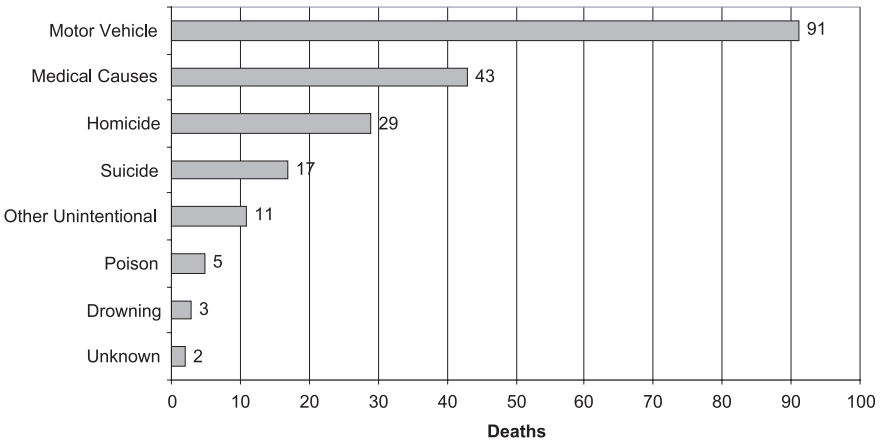
Findings

- 54% of deaths in this age group were caused by injuries
- 55% of those injuries were motor vehicle related, representing a decrease from 2001 (59%)

Findings

- Deaths from motor vehicles (91) and suicide (17) represented the largest decreases in this age group (from 107 and 27 respectively)
- 78% of all deaths in this age group were due to unintentional and intentional injuries
- 58% of injury related deaths were due to motor vehicle related incidents

Figure 6. Causes of Death, Children Ages 15 to 17, Georgia, 2002



ALL 2002 REVIEWED DEATHS

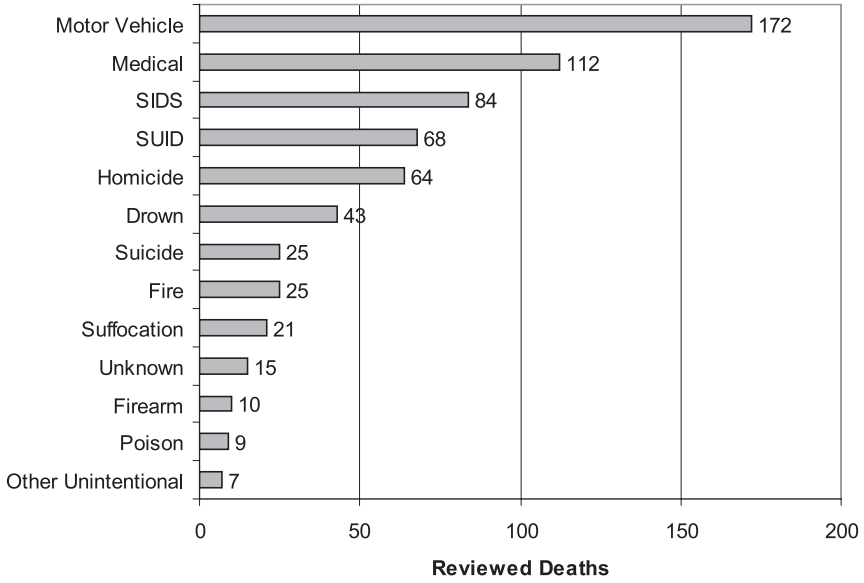
In 2002, 601 of the total 1,795 child deaths met the criteria requiring review (injuries and SIDS) according to death certificate data. Committees filed reports for 88% (528) of those deaths within the reporting period, representing an increase of 13% since 2001. (This increase is attributed to extensive training and consultation provided to the counties, and the counties' commitment to the children of their communities.) Committees reviewed an additional 127 child deaths for a total of 655 deaths reviewed.

The distribution of child deaths in Georgia is generally proportional to the county population.

- The 12 counties with 10 or more reviewable deaths in 2002 have 48% of the child population and 45% of all reviewable deaths. Those counties reviewed 91% of their 268 reviewable deaths
- One hundred fifteen (115) counties with 1 to 9 reviewable deaths reviewed 285 of their 333 reviewable deaths (86%). Only 15 counties with reviewable deaths did not review any of their reviewable deaths, and ten of those counties had only 1 reviewable death
- Ten counties had no child fatalities in 2002, and an additional 22 counties had no child fatalities that met the review criteria

Five hundred forty-three (543) deaths, (injuries and SIDS), are discussed in the "Reviewed Deaths" sections of this report. Reviews of medical deaths are not included unless noted.

Figure 7. Cause of Death, All Reviewed Infant/Child Deaths, Georgia, 2002



Findings

- Motor vehicle incidents continued as the leading cause of injury related deaths among children
- The number of reveiwed deaths associated with SIDS decreased in 2002 because committees had a SUID option if there was a possible contributing factor
- CFR committees identified 68 deaths related to SUID

Preventability

Each child fatality review report asks the committee to determine whether the child's death could have been prevented. Only 7 of the 655 reviews submitted in 2002 omitted this information. Of the remaining 648 reports addressing preventability, teams reported the following:

Definitely Preventable	**38%**
Possibly Preventable	**39%**
Not Preventable	**23%**

The CFR committees' determination of preventability depended on the cause of death (see Appendix C.4).

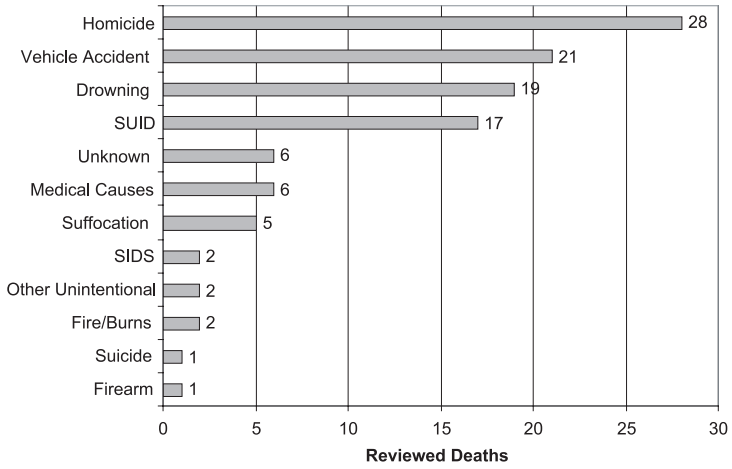
- Forty-three percent (43%) of unintentional deaths were determined to be definitely preventable
- Fifty-three percent (53%) of intentional deaths were determined to be definitely preventable
- Sixty-six percent (66%) of deaths related to abuse/neglect were determined to be definitely preventable

Child fatalities are the most tragic consequence of maltreatment. In 2001, approximately 903,000 children were victims of abuse and/or neglect within the United States. One thousand three-hunded (1,300) of those children died as a result of abuse/neglect. Infants are at greatest risk for dying from homicide during the first week of infancy, with the risk being highest on the first day of life. In the United States, children younger than 1 year accounted for 41% of fatalities related to child abuse/neglect and 85% were younger that 6 years of age. More than 34% of those deaths were associated with neglect, making this the leading cause of maltreatment death. In Georgia, every 30 minutes a child is the victim of confirmed abuse or neglect.

One hundred-ten (110) reviewed child deaths were determined by child fatality review committees to have been suspected (47) or confirmed (63) child abuse and/or neglect. (Data on the cause of death, age, race, and gender for those deaths are included in Appendix C.3 of this report.) A history of domestic violence in the home of the decedent was also associated with a committee finding of child abuse. For those decedents with prior abuse/neglect findings (suspected or confirmed), 32% had a history of domestic violence. Only 9% of the decedents with no abuse/neglect findings had a history of domestic violence.

"8 month-old died as a result of blunt force injuries to the head and abdomen. He was shaken and beaten. Child also had burns on his face, shoulder and neck. Mother's boyfriend was watching the child while mother slept."

Figure 8. Cause of Death, Reviewed Deaths with Abuse/Neglect Finding, Georgia, 2002

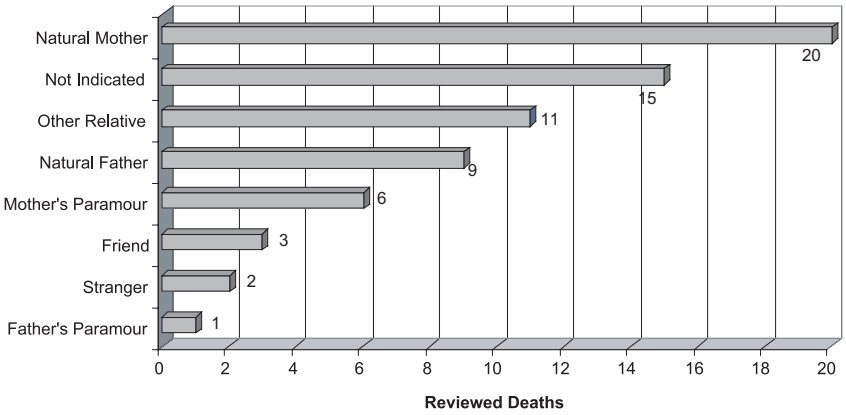


Findings

- 25% of the reviewed deaths with child abuse or neglect findings were homicides
- Total number of deaths with abuse or neglect findings increased from 94 in 2001 to 110 in 2002

Perpetrators

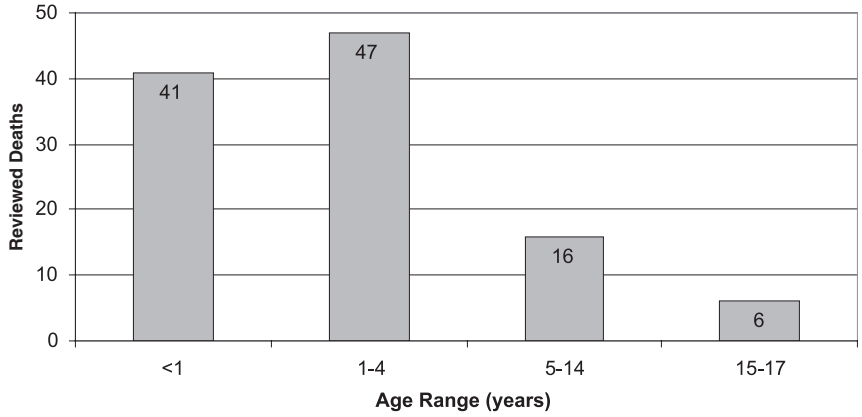
Figure 9. Relationship of Perpetrator to Decedent in Reviewed Cases with Abuse and Neglect, 2002



Finding

- 56% of the identified perpetrators were the child's natural parents

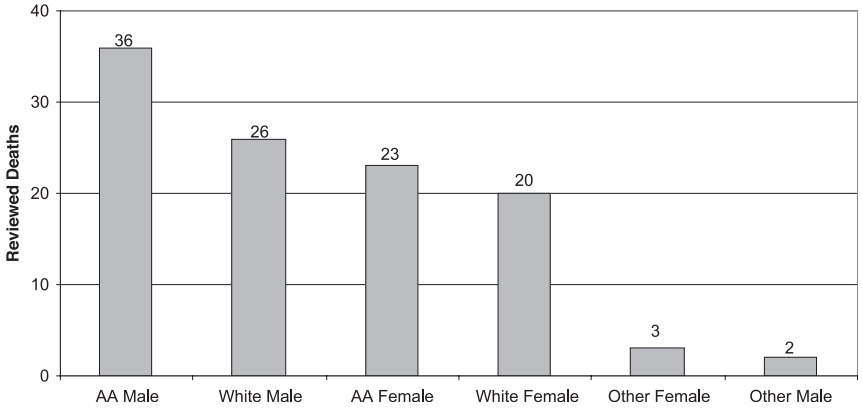
Figure 10. Age Distribution for Reviewed Deaths with Abuse or Neglect Findings, 2002



Findings

- 80% of the deaths were under the age of 5
- The number of cases of abuse or neglect increased 58% for <1 year olds (from 26 in 2001 to 41 in 2002)

Figure 11. Reviewed Deaths with Abuse or Neglect Findings by Race and Gender, 2002



Findings

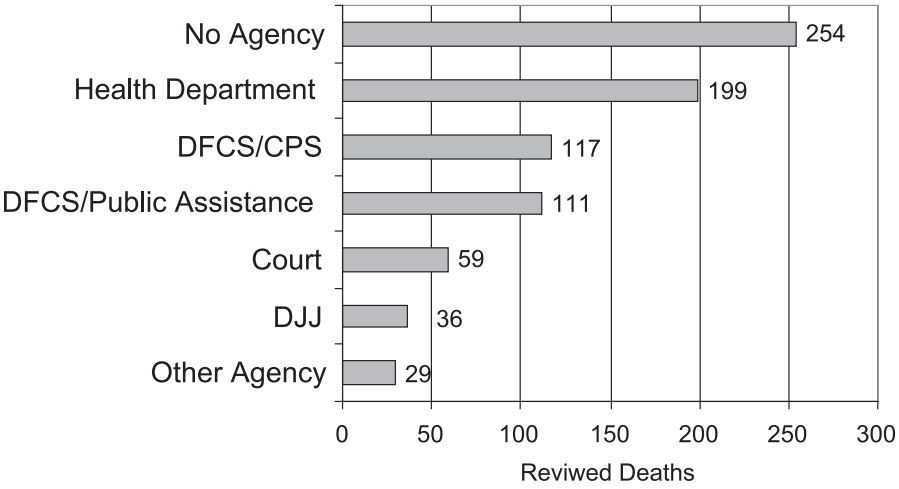
- 54% of deaths were African-American children
- 58% of victims were males with A-A males representing the largest single group

Opportunities for Prevention

- Promote prevention of child maltreatment as a community endeavor, adhering to proven prevention practices within all sectors of the community
- Expand home-based family support and visitation programs to prevent abuse and neglect
- Adopt a Child Endangerment law that penalizes adults who knowingly place children in dangerous situations and circumstances
- Authorize DFCS to access law enforcement and court records regarding domestic violence in order to better assess the safety of children referred to their care
- Encourage Child Abuse Protocol Committees and Child Fatality Review Committees to take a proactive role in informing communities about prevention needs and successful prevention strategies
- For more information on child abuse prevention, please contact Prevent Child Abuse Georgia (800) 532-3208 or www.preventchildabusega.org

Fifty-six percent (367) of all 655 child fatality review reports received for 2002 indicated that one or more community agencies had prior interaction with the deceased child or his/her family. Agencies were not necessarily actively involved with children or families at the time of death. The following figures list the agencies and the number of deaths in which they were identified. A child or family was often involved with more than one agency; therefore, the number of involvements children/families had with agencies exceeded the number of deaths.

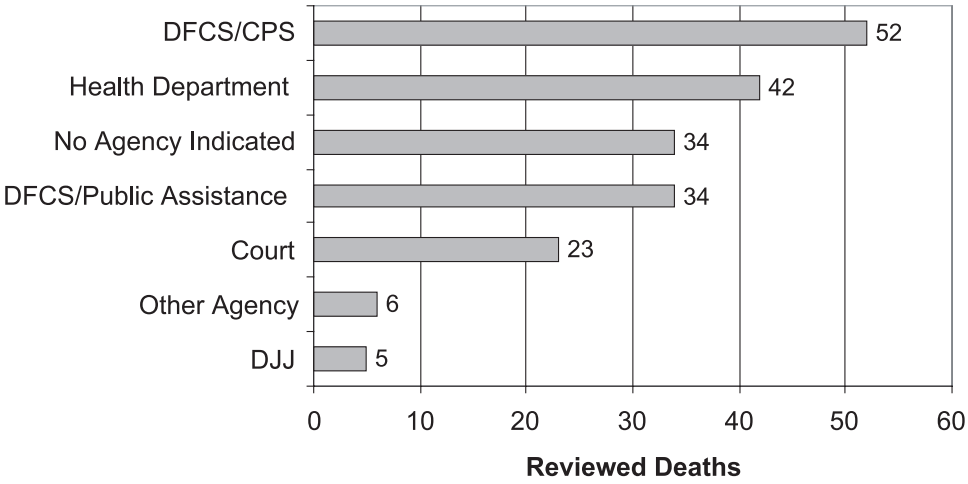
Figure 12. Agency Involvement: Reviewed Deaths with No Child Abuse/Neglect Findings, 2002



Findings

- 53% of deaths (291) with no abuse findings had prior agency involvement
- Families had involvement with an average of 1.9 agencies
- 34% of families had involvement with the Department of Family & Children Services
- 37% of families had involvement with Public Health

Figure 13. Agency Involvement: Reviewed Deaths with Child Abuse/Neglect Findings, 2002



Findings

- 69% of deaths (76) with abuse findings had prior agency involvement
- Families had involvement with an average of 2.1 agencies
- Of the 110 deaths that were determined to be suspected or confirmed abuse/neglect, 47% (52) had prior CPS involvement
- 38% of families had involvement with Public Health
- For the 52 children/families known to Child Protective Services, 4 reports did not indicate the nature of the involvement. Involvement for the remaining 48 children/families is listed in the chart to the left

Decedent	3
Both decedent and another child in the family	14
Another child in the family, not the decedent	8
Decedent, another child in family, and caretaker	8
Caretaker	7
Other Child and caretaker	4
Decedent and caretaker	4

SUDDEN INFANT DEATH SYNDROME

Sudden Infant Death Syndrome (SIDS) is the sudden unexpected death of an infant in whom a thorough post mortem examination (autopsy) fails to demonstrate a cause of death. SIDS is the major cause of death in infants from 1 month to 1 year of age, with most deaths occurring between 2 and 4 months. SIDS claims the lives of almost 3,000 infants in the U.S. every year - nearly 9 babies every day.

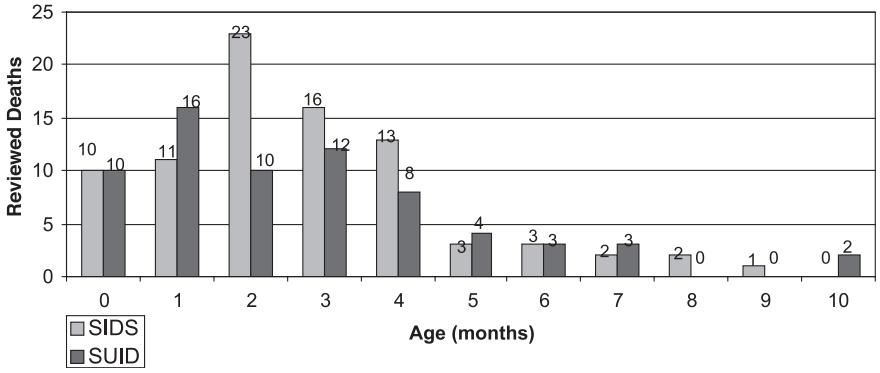
In Georgia, 2002 death certificate data listed 141 infant deaths as SIDS. (This was an increase from 116 SIDS deaths in 2001.) Death certificate data showed an additional 16 deaths that listed SIDS as the secondary cause. Child fatality review committees attributed SIDS or SUID to 152 deaths. Committees used "Sudden Unexplained Infant Death" (SUID) to describe child deaths that appeared to be SIDS, but had other factors present that could have contributed to the infant's death (e.g., overlay, soft bedding, etc.). Through the child fatality review process, committees were able to analyze those 152 deaths by reviewing the autopsy reports, death scene investigation reports, and medical histories. CFR committees concluded that 84 deaths were SIDS and 68 were SUID.

Co-sleeping, a term that is used to describe infants sleeping in adult beds with one or more individuals, was found to be a common factor in deaths that were coded as SIDS by death certificate data but determined to be SUID by child fatality review committees. Child fatality review committees found that 58 of the deaths coded SIDS as either the primary or secondary cause involved co-sleeping. Child fatality review committees also found that 10 of the 21 reviewed deaths attributed to suffocation involved an unsafe sleeping environment.

The 71 infant deaths that occurred while co-sleeping strongly support the importance of additional prevention activities related to promoting safe sleeping environments for infants. Putting babies to sleep on their backs plays an important role in keeping them safe; however, it is only part of the solution. Promoting a safe sleeping environment combined with the continuation of the "Back to Sleep" campaign will further reduce the risk factors associated with SIDS and SUID.

Five week old in a twin bed with his mother and 2 year old sibling. Infant died of compression asphyxia while co-sleeping.

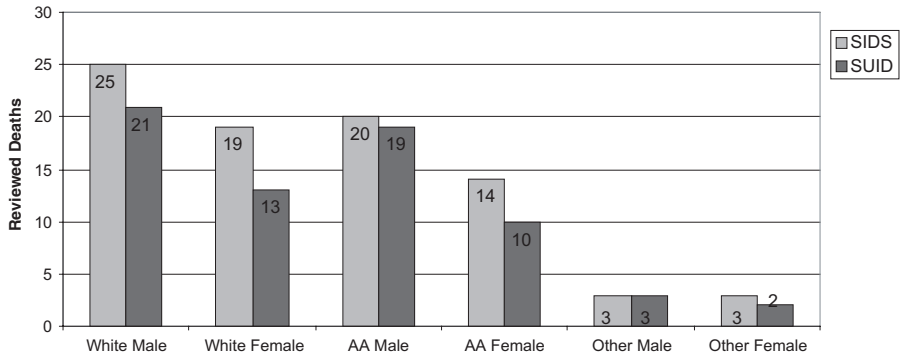
Figure 14. Reviewed SIDS/SUID Deaths by Age, 2002



Findings

- The distribution of deaths by age are similar for reported SIDS and SUID
- 71% of SIDS deaths and 71% of SUID deaths occurred in infants under 4 months of age

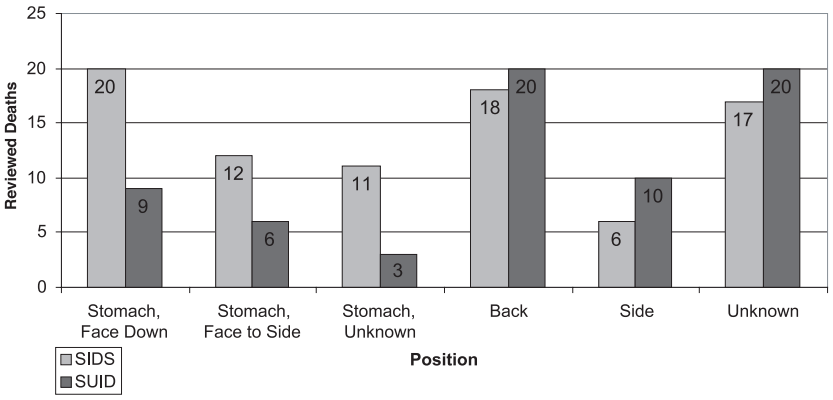
Figure 15. Reviewed SIDS/SUID Deaths by Race and Gender, 2002



Findings

- The racial proportions for reviewed SIDS and SUID deaths are similar. 41% of all SIDS deaths and 43% of all SUID deaths were African American infants
- 57% of all SIDS deaths and 63% of all SUID deaths were male

Figure 16. Sleeping Position of Infants Who Died of SIDS / SUID, 2002

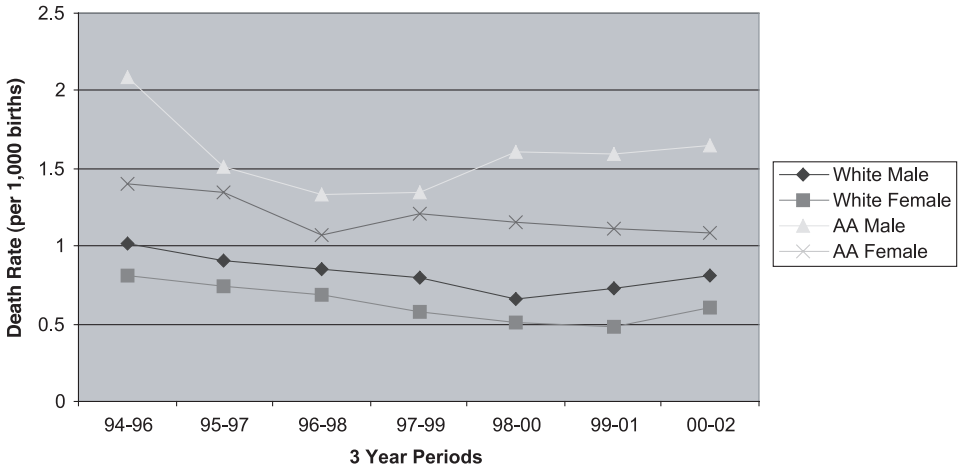


Findings

- Approximately 64% of the SIDS deaths were reported to have been on their stomach when discovered
- Only 38% of the SUID infants were on their stomach

SIDS TRENDS

Figure 17. SIDS Death Rates per 1,000: Age <1, Three Year Moving Average, 1994-2002



Findings

- The three year rates have remained fairly stable since the 1995-1997 period
- Males are about 1.5 times more likely than females to die from SIDS
- African Americans are twice as likely as white infants to die due to SIDS

Three week old infant placed on her back in a bassinet after being bathed and fed. Found on stomach unresponsive. Autopsy findings were consistent with SIDS. Baby was exposed to cigarette smoking in the home.

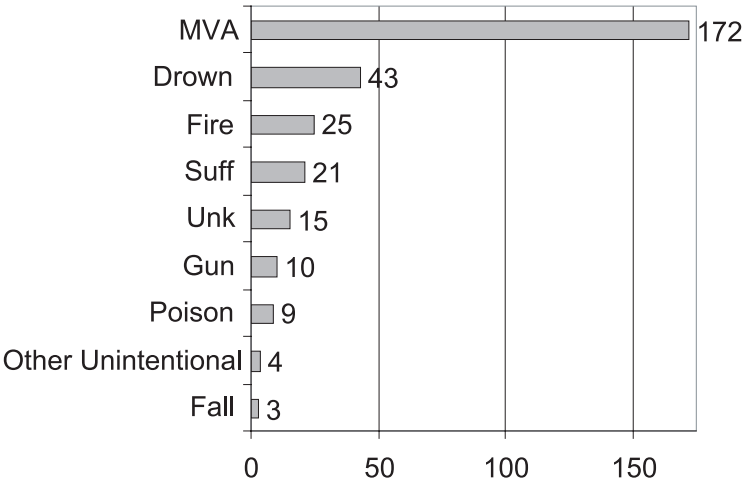
Opportunities for Prevention

- Increase public awareness of a safe sleeping environment by encouraging parents to: remove bumpers and toys from the crib, secure the blanket by tucking the edges under the mattress, never place a child's crib next to a window or blinds, never leave a pillow in the crib, and do not place a baby on a waterbed, sofa, soft mattress, pillow or other soft surface to sleep
- Continue the "Back to Sleep" campaign which educates the public on the risks associated with SIDS, including a focused effort in the African American community
- Incorporate risk reduction information as well as the dangers of overlay when bed sharing in prenatal education for expectant parents
- For more information on SIDS, contact Georgia SIDS Project (678) 342-3360 or SIDS Alliance (National) 1-800-221-SIDS (7437)

UNINTENTIONAL INJURY RELATED DEATHS

Death certificate data indicated injuries claimed the lives of 416 children in 2002. Three hundred thirty-three (333) of those deaths were unintentional. Child fatality review committees reviewed 287 injury-related deaths determined to be unintentional. Figure 18 shows the distribution of those deaths by type of injury. Committees could not determine the cause of 15 child deaths.

Figure 18. Reviewed Unintentional Injury-Related Deaths by Cause, 2002



Findings

- 172 unintentional deaths (60%) resulted from motor vehicle-related incidents
- 41% (118) of unintentional injury-related deaths occurred among children under the age of 5

MOTOR VEHICLE–RELATED DEATHS

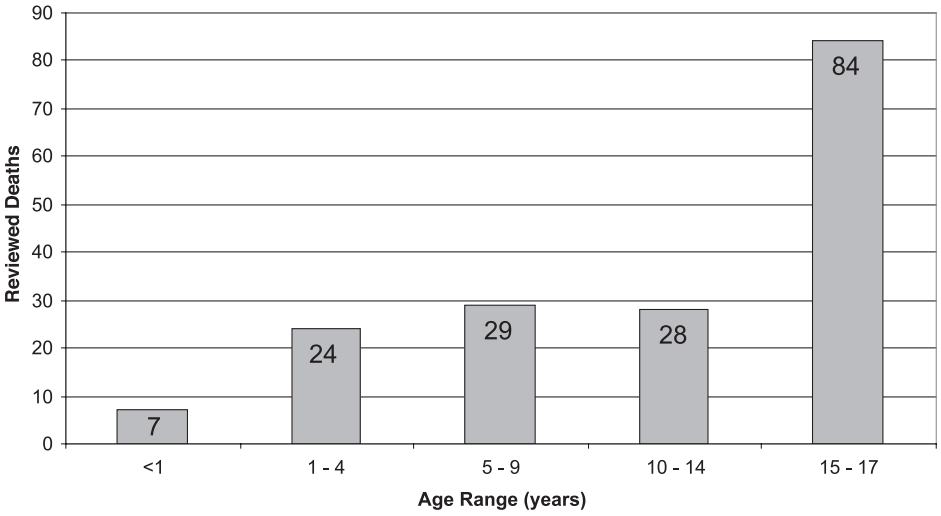
Nationally, motor vehicle crashes continue to be the leading cause of *unintentional* injury-related deaths for children ages 1-14, and account for more than 40% of all injury related child deaths. Pedestrian injuries are the second leading cause of unintentional deaths among children between the ages of 5 and 14. Approximately 56% of children ages 14 and under are killed while riding unrestrained, and nearly one-third of children ride in the wrong restraints for their age and size, placing them at twice the risk of death and injury than those riding properly restrained. Fifty-three percent (53%) of teen driver deaths due to motor vehicle crashes occur on weekends. Teen drivers killed in motor vehicle crashes are also more likely (45%) to have a youth passenger in their automobile.

In Georgia, from 1994 to 2000, 225 children ages 5-12 were killed in motor vehicle crashes while riding in vehicles. Of these 225 children, 110 (49%) were not restrained in any way. Teenagers in Georgia are disproportionately represented in motor vehicle related deaths. While 15-19 year olds are only 7 percent of the state's population, they represent 12% of all crash deaths.

Death Certificate data indicated that 192 child deaths resulted from motor vehicle related incidents. This number has decreased from 224 in 2001. Child fatality review committees reviewed 172 child deaths related to motor vehicle incidents. Of the 172 reviewed motor vehicle deaths, 46 were drivers, 80 were passengers, 28 were pedestrians, 4 involved bicycles, and 8 involved ATV's. According to child fatality review committees, when use of restraint was known, 57% of all fatalities were unrestrained.

A 4 year old toddler was riding in the rear passenger seat of a vehicle driven by her mother. The mother ran a red light while talking on her mobile phone and was hit by another vehicle. The 4 year old was not restrained and was ejected from the car. She died several hours later from massive head injuries.

Figure 19. Reviewed Motor Vehicle-Related Deaths by Age, 2002



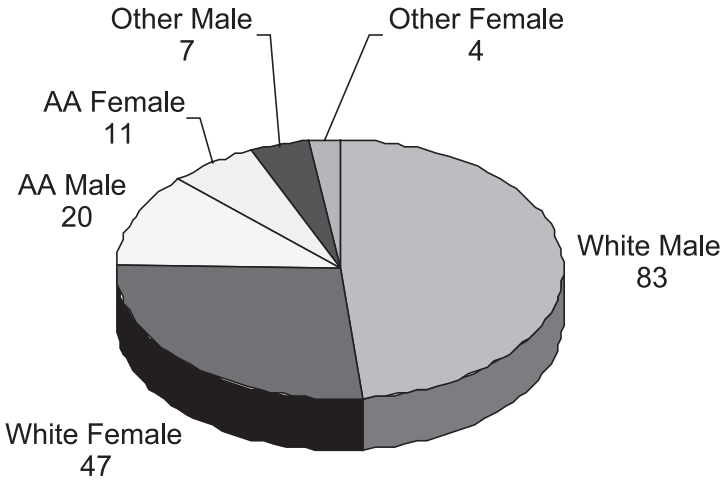
Finding

- 49% of reviewed motor vehicle related deaths occurred among children 15-17

Age 15	12 deaths
Age 16	30 deaths
Age 17	42 deaths

A 9 year old female was riding an ATV with two other children. The ATV caught a tree root and flipped over throwing two of the passengers off. The ATV fell on top of the 9 year old, crushing her underneath. She died of blunt force trauma and liver lacerations. None of the children were wearing helmets.

Figure 20. Reviewed Motor Vehicle-Related Deaths by Race and Gender, 2002

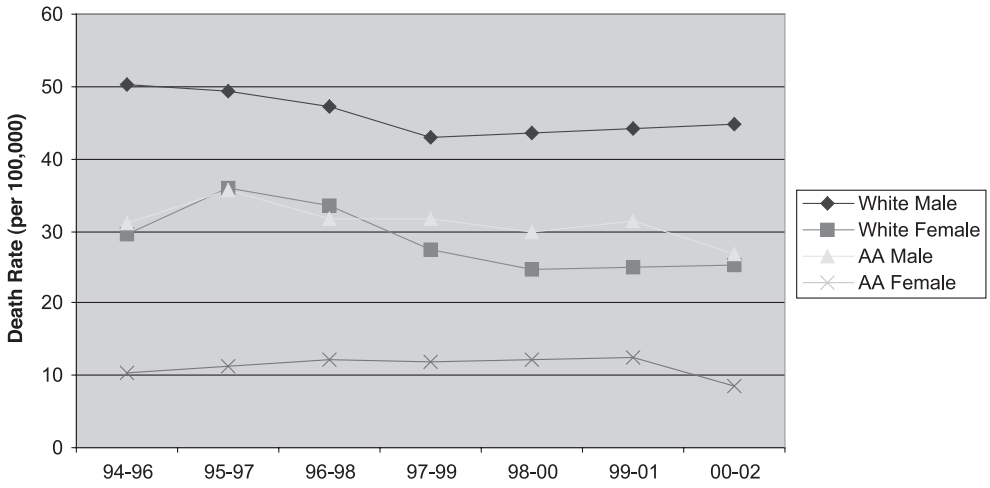


Findings

- 64% of all motor vehicle related deaths involved males
- 48% of deaths involved white males
- 76% of all motor vehicle related deaths involved white children

Motor Vehicle Related Trends

Figure 21. Motor Vehicle-Related Death Rates per 100,000. Ages 15-17, Three-Year Moving Average, 1994-2002



Findings

- Approximately 100 teens ages 15-17 die each year in motor vehicle related incidents in Georgia. The death rate has decreased slightly over the 9 year period
- White males comprise about 50% of the deaths, with white females adding another 25%
- The total and all race-specific rates have shown little change over the last 6 years

Opportunities for Prevention

- Enforce the Teenage and Adult Driver Responsibility Act, with a stronger focus on the role of the parent
- Support statewide availability of driver education programs
- Encourage pedestrian safety campaigns
- Continue to promote bicycle helmet use including education about proper fit and wearing position and establish funding to support community programs that provide helmets to families with young children in need of financial assistance to purchase safety equipment
- Promote educational programs to teach proper installation and use of car seats and proper use of vehicle restraints
- Encourage communities to provide car seats to families with infants and young children who need financial assistance to purchase safety equipment
- Support legislation strengthening the requirements of Georgia's child restraint law to provide for the use of booster seats for children over age 4
- Encourage increased enforcement of child restraint and seat belt law
- For more information on prevention of motor vehicle crashes and the proper use of child safety seats & seat belts, please contact the National Highway Traffic Safety Administration, 1-888-DASH-2-DOT or the National Center for Injury Prevention and Control (770) 488-1506 www.cdc.gov/injury

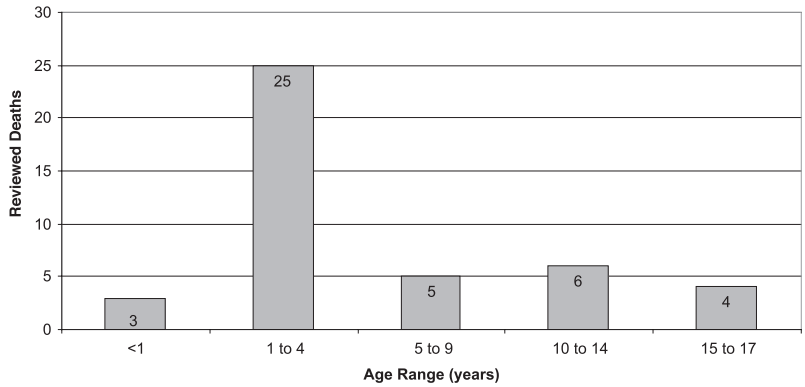
Drowning Deaths

In the United States, drowning is the second leading cause of unintentional injury-related deaths of children ages 1-14. Children 4 and under are 14 times more likely to die in a swimming pool than a motor vehicle. Seventy percent (70%) of all preschoolers who drown are in the care of one or both parents; Seventy-five percent (75%) are missing from sight five minutes or less.

In 2002, Georgia death certificate data indicated 44 children died from drowning (an increase of 4 from 2001). Child fatality review committees reviewed 43 drowning related deaths of children birth through 17 years. Committees determined that none of the children who drowned were wearing floatation devices. Supervision was addressed in 35 of the 43 reviewed deaths, and was determined to be inadequate in 89% of those deaths.

A 7 month old male drowned after his mother left him and his 2 year old brother in the bathtub and went to the kitchen to cook dinner. She returned 15 minutes later and found the infant face down in the tub and toddler screaming.

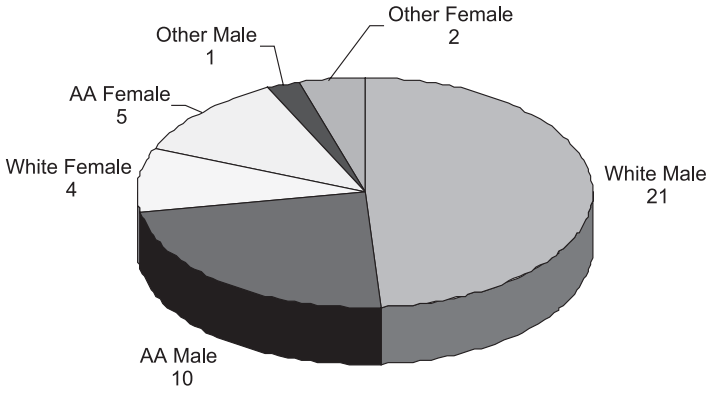
Figure 22. Reviewed Drowning Deaths by Age, 2002



Finding

- 65% of drowning victims were children under the age of 5.

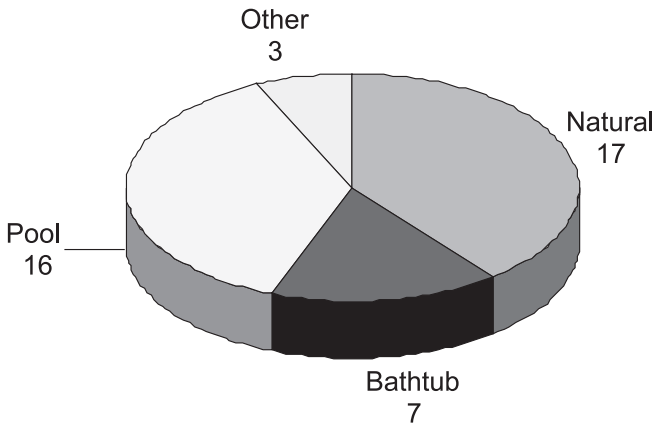
Figure 23. Reviewed Drowning Deaths by Race and Gender, 2002



Findings

- 74% of all drowning victims were male
- 58% of all drowning victims were white

Figure 24. Reviewed Deaths by Place of Drowning, 2002



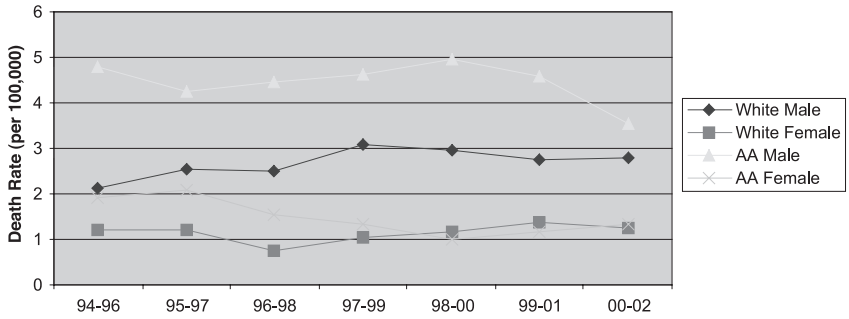
Findings

- Total number of drowning deaths in pools and natural bodies of water increased by 6 and 7 respectively

- 29 reviews indicated child entered water unattended

Drowning Trends

Figure 25. Drowning Death Rates per 100,000: Ages <18, Three-Year Moving Average 1994-2002



Findings

- African-American males have the highest rate of drowning deaths
- Over the past 9 years an average of 49 children drowned each year in Georgia

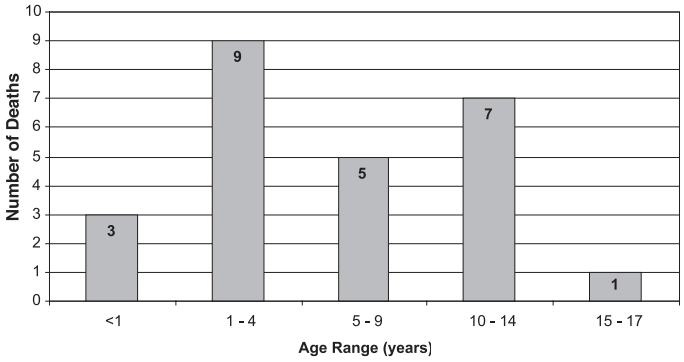
Opportunities for Prevention

- Encourage Department of Natural Resources to establish stronger rescue capabilities at state swimming facilities
- Enact and enforce statewide ordinances related to fences and gates in both public and private swimming facilities
- Increase public education efforts that teach water safety and skills to children
- Educate parents on the importance of complete supervision especially when living or playing near bodies of water and on the importance of using approved personal floatation devices for children in and around open bodies of water and pools
- Enact and support legislation related to installation of four-sided isolation fencing for public and private swimming facilities
- For more information on prevention of drowning please contact the National SAFE KIDS Campaign at (202) 662-0600 www.safekids.org or American Red Cross (202) 303-4498 www.redcross.org

Fire/Burn Related Deaths

The United States holds the worst fire record in the entire industrialized world. Children and elderly citizens account for an overwhelming number of fire fatalities because they are frequently unable to leave a burning house without assistance. Over 80% of the fire related deaths in the United States are residential. More than one-fifth of residential fires are related to the use of supplemental heaters such as wood/coal burning stoves, and kerosene, gas, and electric heaters. In 2002, Death Certificate data indicated 22 fire related deaths. This number decreased from 23 deaths in 2001. After careful investigation, child fatality review committees reviewed 25 deaths they attributed to fire/burn. This number includes 1 scalding death. For fire related deaths, 10 were caused by matches/lighters/candles/cigarettes, and 9 deaths were caused by faulty wiring. The source of fire for the remaining 5 deaths was unknown.

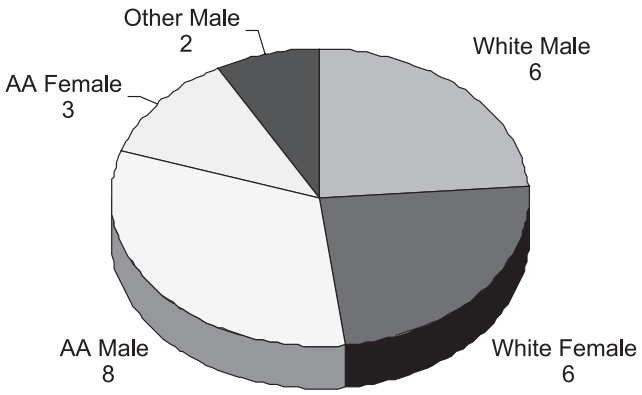
Figure 26. Reviewed Deaths Due to Fire by Age, 2002



Findings

- 68% of all fire-related victims were under the age 10
- The number of deaths for children ages 10 through 14 increased

Figure 27. Reviewed Deaths Due to Fire by Race and Gender, 2002

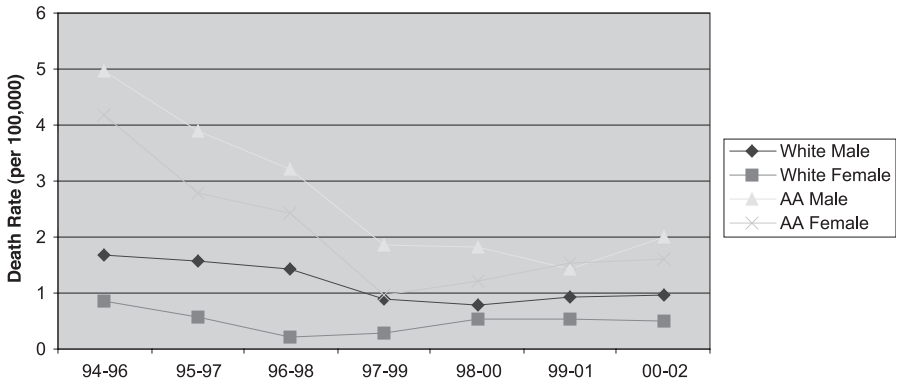


Findings

- African American children make up 44% of all fire-related deaths
- Male victims make up 64% of all fire-related deaths

Fire-Related Trends

Figure 28. Fire-Related Death Rates per 100,000: Ages <18, Three-Year Moving Average, 1994-2002



Findings

- There have been an average of 21 fire related deaths in Georgia over the past 6 years. For 1994-1996, there was an average of 47 deaths per year
- African American children are twice as likely to die in fires as White children

Two brothers (9 months and 2 years old) were in a rear bedroom unsupervised. The 2 year old started playing with a cigarette lighter. The mother claims that she was in the house and could not save the children. However, police believe that the mother was not home when the fire started.

Opportunities for Prevention

- Promote public awareness about the importance of changing smoke detector batteries every 6 months
- Provide smoke detectors and batteries to families who cannot financially afford them
- Continue to teach fire prevention programs in school which include topics such as: "Stop, Drop and Roll"; Home Fire Escape Planning; smoke alarm installation and maintenance; and match, lighter and cigarette safety
- For more information on the prevention of fire-related deaths and burn prevention, please contact the United States Fire Administration, www.usfa.gov or the Georgia Firefighters Burn Foundation, (404) 320-6223 or www.gfbf.org, National SAFE KIDS Campaign (202) 662-0600 www.safekids.org

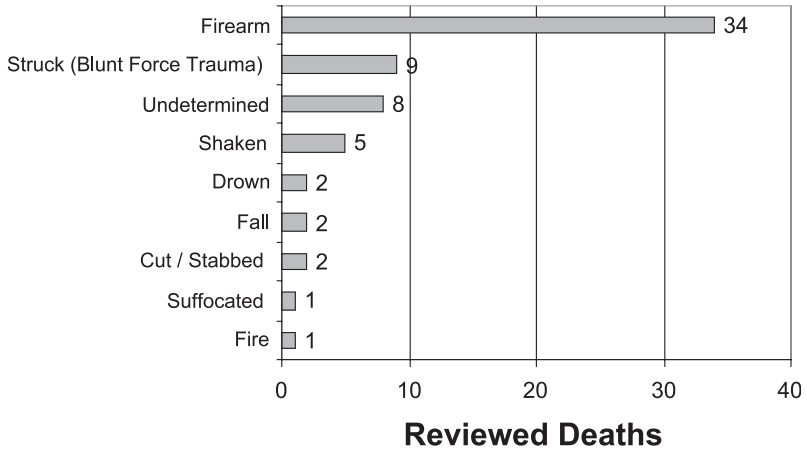
INTENTIONAL INJURY DEATHS

The total number of deaths listed on death certificates as resulting from homicide and suicide (83) indicated a decrease in deaths from intentional causes. In 2002, local child fatality review committees reviewed a total of 89 deaths determined to have resulted from intentional causes. Committees determined more deaths were the result of homicide than those indicated on death certificates.

Homicide

Homicide is the second leading cause of death for people ages 10-19 and the fourth leading cause of death for children ages 1-14 years in the US. Eighty-five percent (85%) of homicides in which both the victim and the perpetrator were children involved a firearm. Homicide rates for young people are higher in the United States than in any other developed nation. In 2002, child fatality review committees reported 64 homicide deaths, which is a 19% increase from 2001 (54). The figure below represents reviewed homicide deaths by circumstance of death.

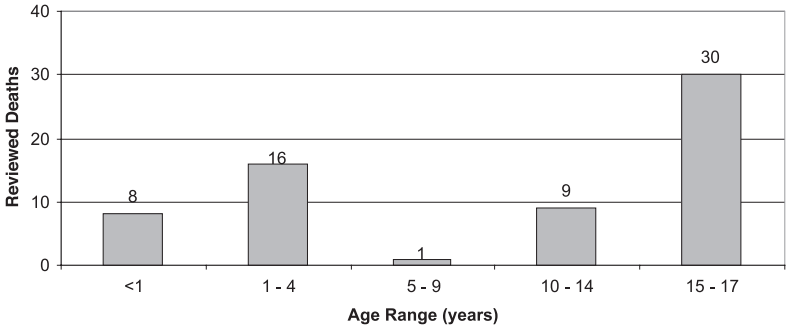
Figure 29. Reviewed Homicide Deaths by Circumstance of Death, 2002



Findings:

- Firearms were determined to be involved in 34 (53%) of the 64 homicide deaths
- 14 deaths (22%) were attributed to blunt force trauma or violent shaking

Figure 30. Reviewed Homicide Deaths by Age, 2002



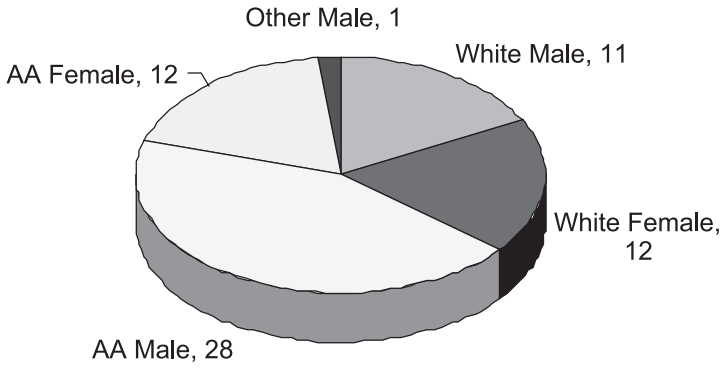
Findings:

- 47% of the 64 reviewed homicides were youth ages 15-17 (29 of the 30 deaths were caused by a firearm)
- 38% of homicide victims were under 5 years of age (12 of the 24 were victims of Shaken Baby Syndrome or blunt force trauma)

Figure 31. Reviewed Homicide Deaths by Race and Gender, 2002

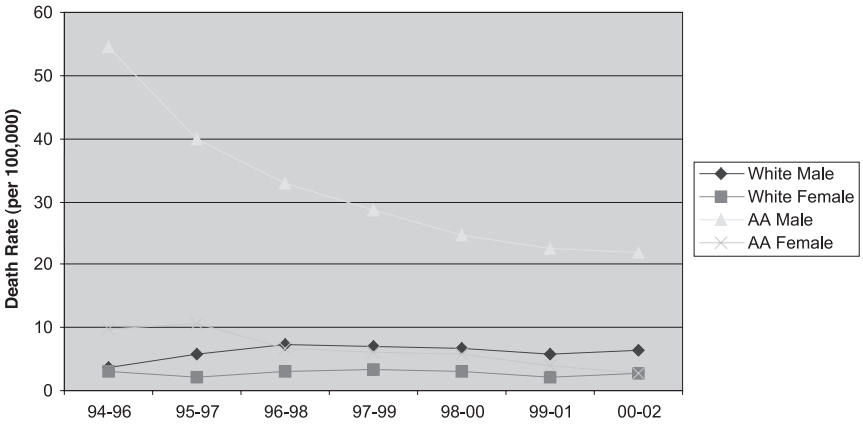
Finding

- 44% of homicide victims were African-American males, and the remainder are distributed evenly among white males, white females, and African-American females



Homicide Trends

Figure 32. Homicide Death Rates per 100,000: Ages 15-17, Three-Year Moving Average, 1994-2002



Findings

- African American males are 5 times more likely than all other teens to be a homicide victim (97-2002)
- African American males (15-17) make up 17% of the teen population, but account for over 50% of all teen homicides
- The decrease in teen homicides over the 9 year period is largely due to the decrease in the African American male homicides
- In the 1994-1996 period, the average number of African American males homicides was approximately 30; However, in the latest 3 year period (2000-2002), the average number is down to 14

Two year old child's death attributed to shaken impact and strangulation, triggered by crying. Toddler was being supervised by the the mother's boyfriend. Boyfriend was arrested and charged.

Opportunities for Prevention

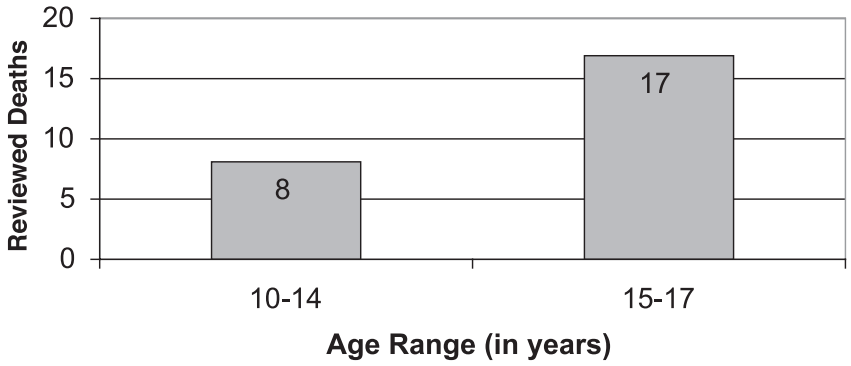
- Promote in-school and after-school programs teaching conflict resolution, impulse control, anger management and empathy
- Support legislation and public service announcements promoting responsible gun ownership including use of firearm safety locks, safe firearm storage, and warnings to parents and other adults of the dangers to children, and liabilities to parents, of keeping loaded firearms in homes occupied or visited by children
- Support legislation requiring American made guns to be subject to federal safety standards as are other consumer products

Suicide

In 2002, 25 children between the ages of 10-17 took their own lives, according to in-depth reviews conducted by local child fatality review committees. Death certificate data also reported a total of 25 suicides for the same age group. This is a decrease of nearly 27% from 2001, when death certificate data reported 34 child deaths resulting from suicide.

There is still a need for communities to educate and increase awareness of suicide warning signs among parents and caretakers.

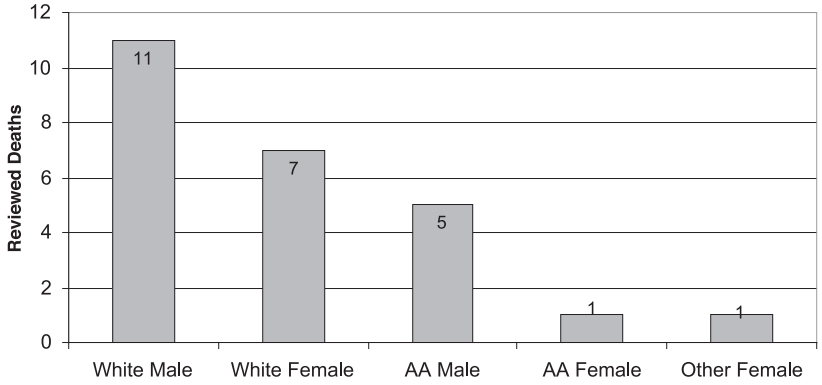
Figure 33. Reviewed Suicide Deaths by Age, 2002



Findings

- 68% (17) of reviewed suicide deaths occurred to teens 15-17. Twelve of those 16 (75%) were 17 years old
- The youngest victim was 11 years old and died by hanging (asphyxia). The victim had previously talked about suicide

Figure 34. Reviewed Suicide Deaths by Race and Gender, 2002



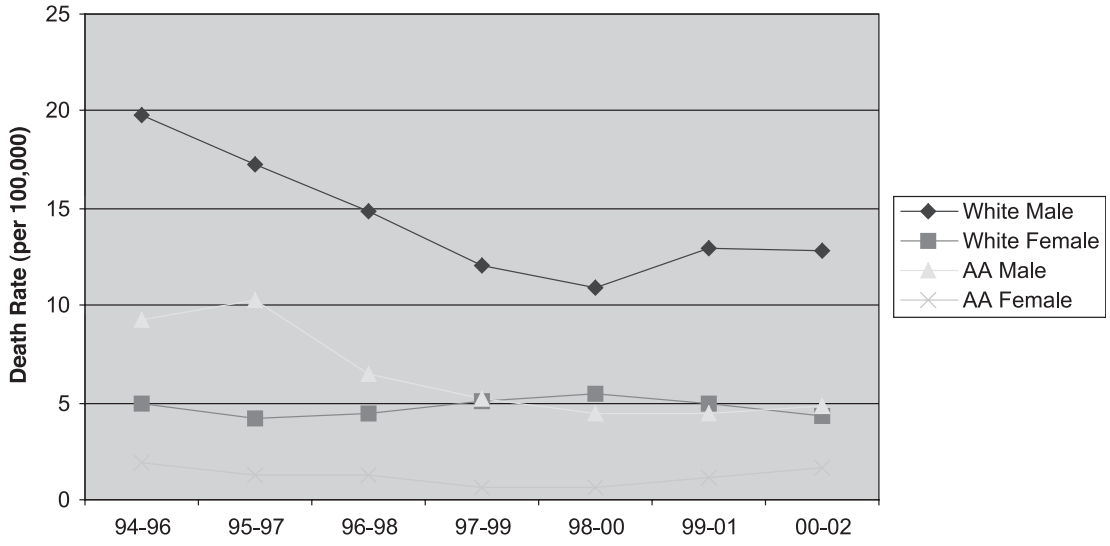
Findings

- 44% of all suicide deaths were White males
- Suicides among African American males and all females increased from 30% in 2001 to 56% in 2002

Other Findings

- Strangulations accounted for 32% (8) of suicide deaths
- Firearms were used in 56% (14) of reviewed suicides
- 10 of the 25 victims (40%) had previously talked about suicide

Figure 35. Suicide Death Rates per 100,000: Ages 15-17, A Three Year Moving Average, 1994-2002



Findings

- The average number of suicides over the last 4 three year periods has been constant
- Males are over 3 times more likely to commit suicide than females
- Rate of Suicide in White males is significantly higher than in any other race/sex category

A teenager with a history of having been sexually abused as a child is found dead from a self-inflicted gunshot wound. This teenager had been having school problems and had a history of acting out in class. The teenager had also been to the hospital several times for treatment for various injuries, including an overdose of drugs. Previous intervention may have been sufficient enough to stop the molestation but did not address other factors and were not adequate enough to provide the child with a healthy environment or the mental health intervention this teen so desperately needed.

Opportunities for Prevention

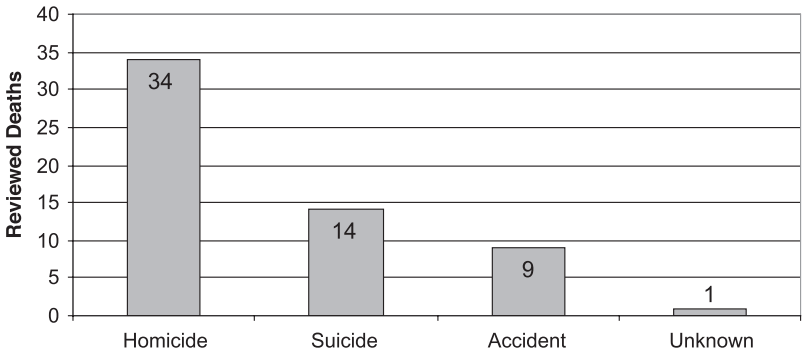
- Increase the access and availability of mental health and substance abuse prevention and treatment services to children and youth
- Increase awareness among parents, caretakers, and communities of suicide warning signs, and promote prompt action when warning signs are recognized
- Develop school-based programs to educate students, faculty and parents on the warning signs of suicide and interventions to develop coping skills
- Advocate for safe home storage of firearms

FIREARM RELATED DEATHS

Children ages 5 to 14 years old in the United States, "are dying at dramatically higher rates in states with more guns" according to a study from Harvard School of Public Health. The unintentional firearm injury death rate among U.S. children ages 14 and under is 9 times higher than in 25 other industrialized countries combined. Firearm-related mortality affects all demographic groups, but the greatest increase in recent years in the United States was among teens 15-19 years of age (44% increase from 1987-1998). The Violence Policy Center ranked Georgia as being 10th in the rate of children dying from a handgun, and 8th in the rate of children who murder with a handgun from 1995-1999.

In Georgia, death certificate data indicated a total of 61 deaths were caused by firearms. Child fatality review committees reviewed 58 firearm related deaths. Child fatality review reports asked for information not available on death certificate, including source of the firearm, type of firearm, who was using the firearm at the time of death, and the age of the firearm handler. This information provides important guidance for prevention.

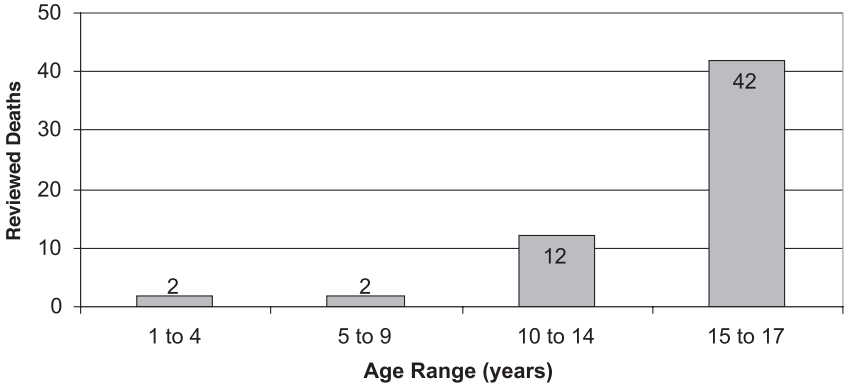
Figure 36. Reviewed Firearm-Related Deaths by Circumstance of Death, 2002



Findings

- 59% of firearm-related deaths were homicides
- A large majority of firearm deaths (83%) among children were intentional

Figure 37. Reviewed Firearm-Related Deaths by Age, 2002

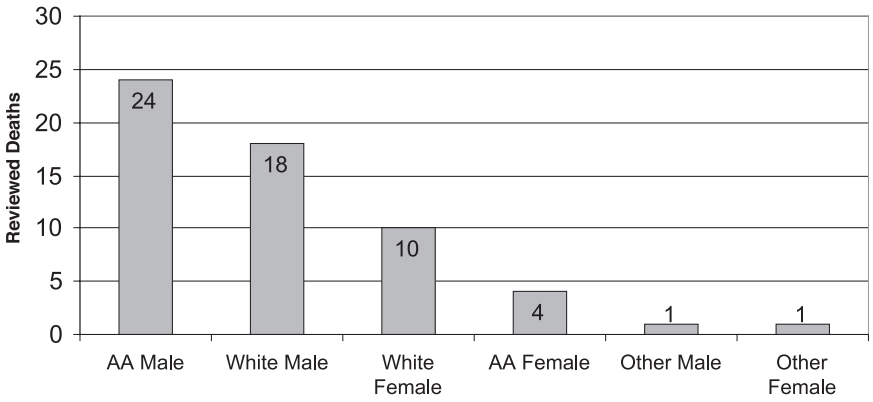


Findings

- Child firearm deaths were concentrated among 15 to 17 year olds (72%)
- 39 of the 42 firearm-related deaths in the 15-17 age group were intentional - 29 homicides (69%) and 10 suicides (24%)

A 3 year old male died of a gunshot wound to the face. The toddler found the unsecured gun in his parent's bedroom and accidentally shot himself.

Figure 38. Reviewed Firearm-Related Deaths by Race and Gender, 2002



Findings

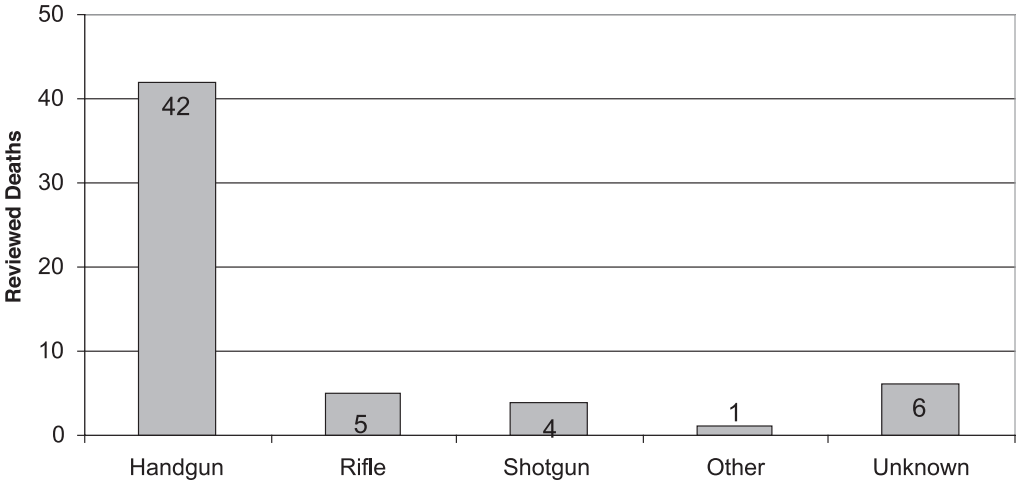
- In 2002, an equal number of firearm-related deaths occurred among white and African-American children
- Males accounted for 74% of all reviewed firearm deaths

Source of Firearm

- The source of the firearm was noted as "Unknown" for half of the reviewed firearm deaths
- Twenty of the deaths with an indicated source identified a person known to the youth (parents, relative, friend)
- A parent was the source of the firearm for 8 of the 14 suicides (57%)

Type of Firearm

Figure 39. Reviewed Firearm-Related Deaths by Type of Firearm, 2002



Findings

- A handgun was used in 42 (81%) of the 52 deaths for which the type of firearm was known

Findings (cont.)

- Of the 25 reviewed suicides, 14 (56%) involved firearms:
  - 10 (71%) = handgun
  - 3 = shotgun
  - 1 = type unknown

- Of the 64 reviewed homicides, over 50% (34) involved firearms:
  - 27 (79%) = handguns
  - 3 = rifle
  - 4 = other type

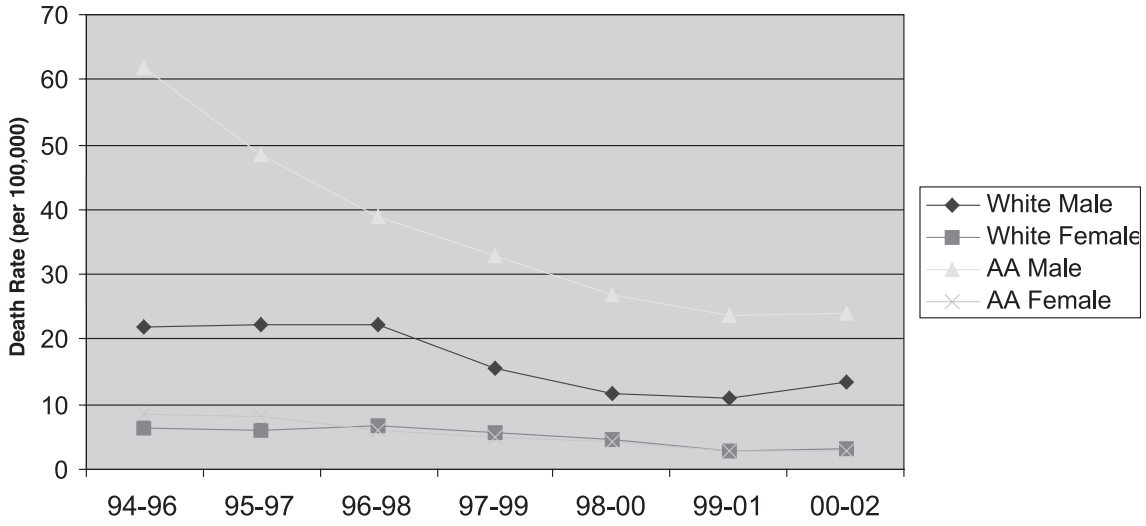
Usage
- In 83% of firearm deaths (48), the shooter was aiming at himself or at someone else
- 9 deaths were unintentional
- The intent of 1 firearm-related death was unknown

Storage
- The gun was unsecured in 18 of the 21 deaths with information on gun storage

Age of Handler
- The shooter was under the age of 18 in 31(67%) of 46 deaths that identified the age of the shooter
- The 15 deaths with a shooter 18 or older were homicides

Firearm Trends

Figure 40. Firearm-Related Death Rates per 100,000: Ages 15-17, Three-Year Moving Average, 1994-2002



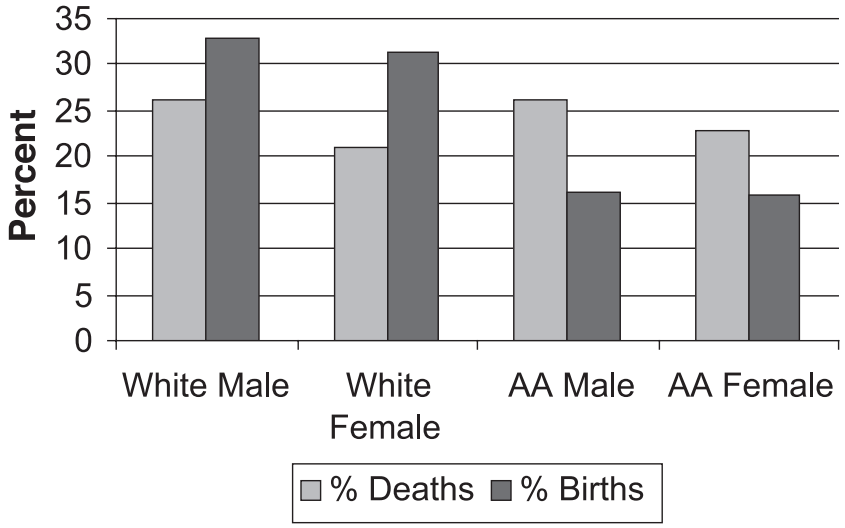
Findings
- The average annual number of deaths due to firearms has increased from 92 in the 1999-2001 period to 105 in the 2000-2002 period
- There has been an increase in the rate of deaths due to firearms in the 2000-2003 period after a steady drop over the previous 6 three-year periods
- The rate in African-American males seems to have reached a plateau after a dramatic decrease from 1994-1996 through 1997-1999

Opportunities for Prevention
- Promote school and community-based risk reduction and firearm safety programs for children, parents and other caretakers
- Promote the use of firearm safety devices, including trigger locks
- Support efforts to limit minors' access to firearms

Data in this report consider such characteristics as race, ethnicity, age, and gender. These are important characteristics to consider in determining who is affected by a particular cause of death. Characteristics shape a person's beliefs and values, and therefore, life experiences. These must be taken into consideration when planning prevention strategies.

Data are presented in this report by race and gender for each type of death to enable more detailed analysis. The terms "White", "African-American" (A-A) and "Other" are used to identify racial groups throughout the report. "Other" refers to children of Asian, Pacific Islander, or Native American origin. Death certificate data includes ethnicity information that can identify children of Hispanic origin. One hundred thirty-two (132) of 133 deaths identified as Hispanic indicated the race as "White". The remaining death was reported as black. The total number of Hispanic infant and child deaths has increased from 95 in 2001 to 133 in 2002.

Figure 41. Deaths to Children < 1 and Percent of Population in Georgia By Race and Gender, 2002

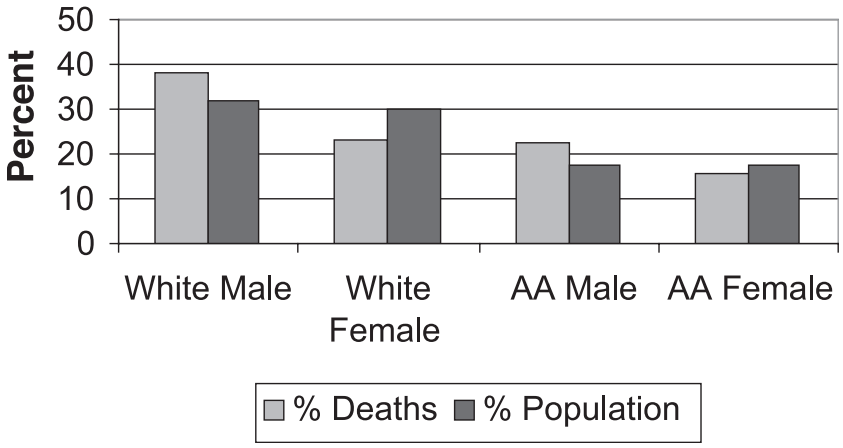


	% of Deaths	% of Population
All A-A Infants	49.2	32.0
A-A-Male Infants	26.3	16.2
A-A Female Infants	22.9	15.8

Findings

- A disproportionate number of deaths occurred among African-American infants
- The infant mortality rate for African-Americans (13.7 per 1,000 births) was more than double the rate for White infants (6.6)

Figure 42. Deaths to Children 1-17 and Percent of Population in Georgia, by Race and Gender, 2002



Finding

• Males between the ages of 1-17 are about 50% more likely to die than females in the same age range

	% of Deaths	% of Population
All Males 1–17	61.1	51.2
AA Males 1–17	22.2	17.6
White Males 1-17	38.4	32.1

THE HISTORY OF CHILD FATALITY REVIEW IN GEORGIA

1990 - 1993

Legislation established the Statewide Child Fatality Review Panel with responsibility for compiling statistics on child fatalities and for making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adopted to:

- Establish a separate child fatality review team in each county and determine procedures for conducting reviews and completing reports
- Require the Panel to:
    1. Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
    2. Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
    3. Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services for child abuse cases

1996 - 1998

- The Panel established the Office of Child Fatality Review with a full-time director to administer the activities of the Panel
- An evaluation of the child fatality review process was conducted by researchers from Emory University and Georgia State University. The evaluation concluded that there were policy, procedure, and funding issues that limited the effectiveness of the review process. Recommendations for improvement were made to the General Assembly
- Statutory amendments were adopted to:
    1. Identify agencies required to be represented on child fatality review teams, and establish penalties for non-participation
    2. Require that all child deaths be reported to the coroner/medical examiner in each county

1999 - 2003

- Child death investigation teams were initially developed in four judicial circuits as a pilot project, with six additional teams later added. Teams assumed responsibility for conducting death scene investigations of child deaths within their judicial circuit
- Statutory amendments were adopted which resulted in the Code section governing the Child Fatality Review Panel, child fatality review committees, and child abuse protocol committees being completely rewritten. This was an attempt to provide greater clarity and a more comprehensive, concise format
- The Panel's budget was increased
- Funding was secured to purchase an on-line reporting system
- Statutory amendments were adopted which resulted in the following:
    1. Appointment of District Attorneys to serve as chairpersons of local committees in their circuits
    2. Authority of the Supeior Court Judge on the Panel to issue an order requiring the participation of mandated agencies on local child fatality review committees. Failure to comply would be cause for contempt
    3. Authority of the Panel to compel the production of documents or the attendance of witnesses pursuant to a subpoena
    4. Director of the Division of Mental Health added as a member to the Panel

APPENDIX A
CRITERIA FOR CHILD DEATH REVIEWS

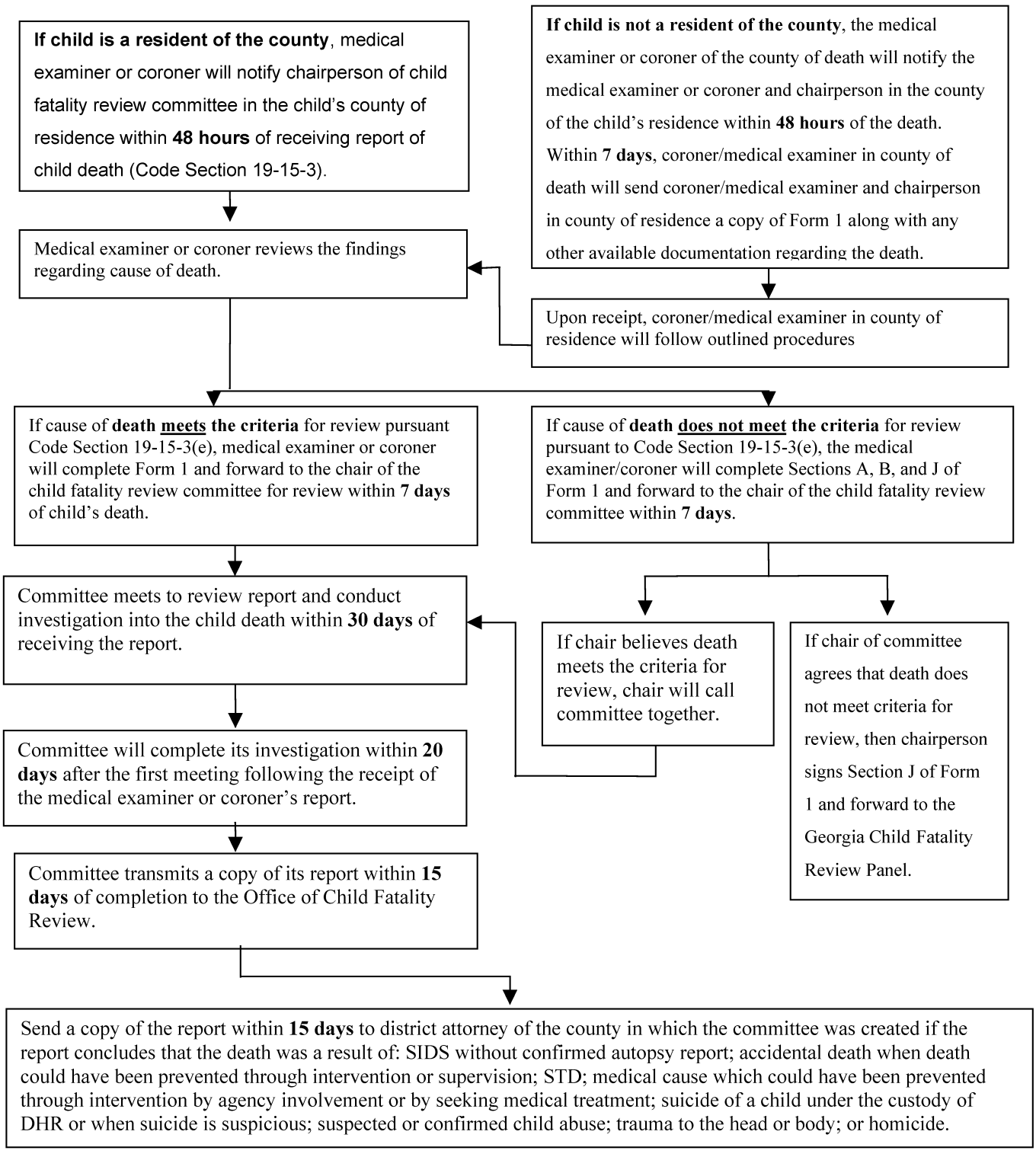
Child Fatality Review Teams are required to review the deaths of all children under the age of 18 that meet the criteria for a coroner/medical examiner's investigation.

"Eligible" Deaths or Deaths to be Reviewed by Child Fatality Review Teams O.C.G.A. 19-15-3(e)

The death of a child under the age of 18 must be reviewed when the death is ***suspicious, unusual, or unexpected***. Included in this definition are incidents when a child dies:

1. as a result of violence
2. by suicide
3. by a casualty (i.e., car crash, fire)
4. suddenly when in apparent good health
5. when unattended by a physician
6. in any suspicious or unusual manner, especially if under 16 years of age
7. after birth but before seven years of age if the death is unexpected or unexplained
8. while an inmate of a state hospital or a state, county, or city penal institution
9. as a result of a death penalty execution

APPENDIX B
CHILD FATALITY REVIEW TIMEFRAMES AND RESPONSIBILITIES



APPENDIX C.1 Total Child Fatalities Based on Death Certificate

Infant (Age<1)	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Drowning	2	2					4
	Fire/Burns	1	1					2
	Homicide			2	4			6
	Medical Causes	246	195	260	229	21	16	967
	Vehicle Accident	2	3	1	1	1		8
	Other Accident	2	1					3
	Poisoning			2	1			3
	SIDS	43	35	35	24	3	1	141
	Other SIDS	8	4	1	3			16
	Suffocation	4	1	5	5			15
	Unknown	4	8	5	3			20
	Unknown Intent			1	2			3
	Total	312	250	312	272	25	17	1188

Ages 1 to 4	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Drowning	17	2	4	3			26
	Fall	1					1	2
	Fire/Burns	2	2	3	1	1		9
	Homicide	3	3	7	2			15
	Medical Causes	24	20	15	25			84
	Vehicle Accident	9	9	6	1		1	26
	Other Accident	2	2	2	1			7
	Poisoning			1				1
	Suffocation	1	1					2
	Unknown	2	1	1				4
	Unknown Intent	1	1	1				3
	Total	62	41	40	33	1	2	179

Ages 5 to 14	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Complications			1	1			2
	Drowning	2	2	4	3			11
	Fire/Burns	2		5	2			9
	Homicide		2	4	2			8
	Medical Causes	31	20	19	28	2		100
	Vehicle Accident	32	20	5	10			67
	Other Accident	7	4	5	1			17
	Poisoning	1						1
	Suffocation	1						1
	Suicide	1	4	3				8
	Unknown	1	1					2
	Unknown Intent			1				1
	Total	78	53	47	47	2		227

Ages 15 to 17	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Drowning	2		1				3
	Falls	1						1
	Fire/Burns	1					1	2
	Homicide	7	5	16	1			29
	Medical Causes	12	9	13	9			43
	Vehicle Accident	52	23	13	3			91
	Other Accident	6		1				7
	Poisoning	1	4					5
	Suffocation	1						1
	Suicide	10	3	3	1			17
	Unknown		1	1				2
	Total	93	45	48	14		1	201

APPENDIX C.2 Total Reviewed Child Fatalities

Infant (Age<1)	Cause of Death	White Male	Female	Black Male	Female	Other Male	Female	Total
	Drowning	1				1	1	3
	Fire/Burns	1	2					3
	Homicide	1		3	4			8
	Medical Causes	12	11	9	18	4	1	55
	Vehicle Accident	2	2		1	1		6
	Poisoning			2	1			3
	SIDS	25	19	20	14	3	3	84
	Suffocation	3	3	6	5	1		18
	SUIDS	21	13	19	10	3	2	68
	Unknown	2	1	3	1			7
	Total	68	51	62	54	13	7	255

Ages 1 to 4	Cause of Death	White Male	Female	Black Male	Female	Other Male	Female	Total
	Drowning	15	3	5	2			25
	Falls	1					1	2
	Fire/Burns	1	2	3	1	2		9
	Accidental Firearm	1						1
	Homicide	3	4	6	3			16
	Medical Causes	6	4	5	6	1		22
	Vehicle Accident	7	9	5		2	2	25
	Poisoning	1		1				2
	Suffocation					1		1
	Unknown	2		1				3
	Other		1	1				2
	Total	37	23	27	12	6	3	108

Ages 5 to 14	Cause of Death	White Male	Female	Black Male	Female	Other Male	Female	Total
	Drowning	2	1	4	3		1	11
	Fire/Burns	4	1	5	2			12
	Accidental Firearm	2	1	2			1	6
	Homicide		3	4	3			10
	Medical Causes	7	5	7	3	1		23
	Vehicle Accident	25	16	3	9	4	1	58
	Poisoning	1						1
	Suffocation					1		1
	Unknown	1		1	1			3
	Suicide	1	4	3				8
	Other	1		1				2
	Total	44	31	30	21	6	3	135

Ages 15 to 17	Cause of Death	White Male	Female	Black Male	Female	Other Male	Female	Total
	Drowning	3		1				4
	Falls	1						1
	Fire/Burns		1					1
	Accidental Firearm	1		2				3
	Homicide	7	5	15	2	1		30
	Medical Causes	2	2	5	2	1		12
	Vehicle Accident	49	20	12	1		1	83
	Poisoning		3					3
	Suffocation	1						1
	Unknown		1	1				2
	Suicide	10	3	2	1		1	17
	Total	74	35	38	6	2	2	157

APPENDIX C.3 Reviewed Child Fatalities with Abuse Findings

Infant (Age<1)	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Drowning	1				1	1	3
	Fire/Burns	1	2					3
	Homicide	1		3	4			8
	Medical Causes	12	11	9	18	4	1	55
	Vehicle Accident	2	2		1	1		6
	Poisoning			2	1			3
	SIDS	25	19	20	14	3	3	84
	Suffocation	3	3	6	5	1		18
	SUIDS	21	13	19	10	3	2	68
	Unknown	2	1	3	1			7
	Total	68	51	62	54	13	7	255

Ages 1 to 4	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Drowning	15	3	5	2			25
	Falls	1					1	2
	Fire/Burns	1	2	3	1	2		9
	Accidental Firearm	1						1
	Homicide	3	4	6	3			16
	Medical Causes	6	4	5	6	1		22
	Vehicle Accident	7	9	5		2	2	25
	Poisoning	1		1				2
	Suffocation					1		1
	Unknown	2		1				3
	Other		1	1				2
	Total	37	23	27	12	6	3	108

Ages 5 to 14	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Drowning	2	1	4	3		1	11
	Fire/Burns	4	1	5	2			12
	Accidental Firearm	2	1	2			1	6
	Homicide		3	4	3			10
	Medical Causes	7	5	7	3	1		23
	Vehicle Accident	25	16	3	9	4	1	58
	Poisoning	1						1
	Suffocation					1		1
	Unknown	1		1	1			3
	Suicide	1	4	3				8
	Other	1		1				2
	Total	44	31	30	21	6	3	135

Ages 15 to 17	Cause of Death	White Male	White Female	Black Male	Black Female	Other Male	Other Female	Total
	Drowning	3		1				4
	Falls	1						1
	Fire/Burns		1					1
	Accidental Firearm	1		2				3
	Homicide	7	5	15	2	1		30
	Medical Causes	2	2	5	2	1		12
	Vehicle Accident	49	20	12	1		1	83
	Poisoning		3					3
	Suffocation	1						1
	Unknown		1	1				2
	Suicide	10	3	2	1		1	17
	Total	74	35	38	6	2	2	157

APPENDIX C.4 Preventability for Reviewed Deaths with Suspected or Confirmed Abuse or Neglect

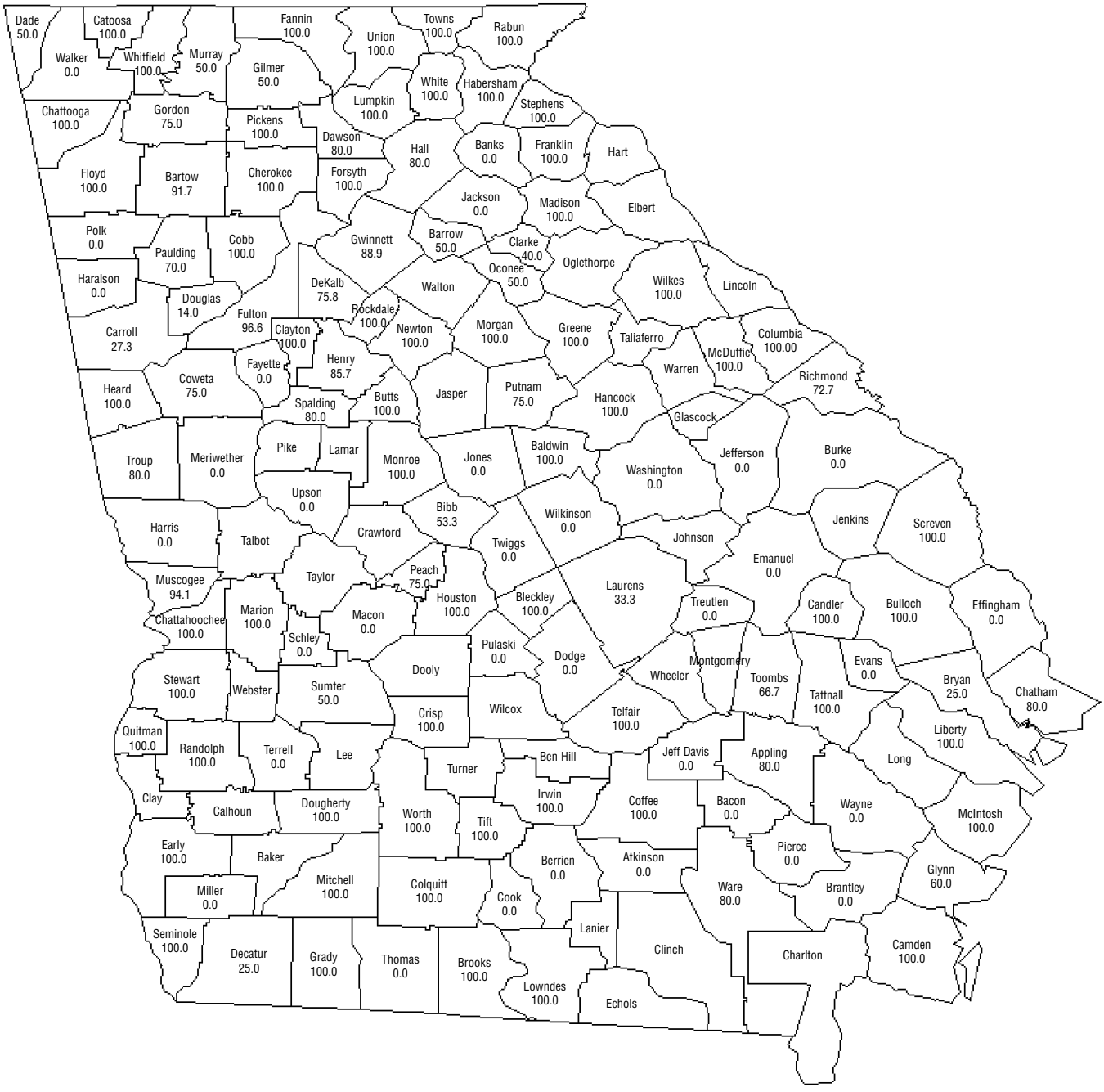
Cause of Death	Preventability: Not at All	Possibly	Definitely
Drowning	1	2	12
Falls			1
Fire/Burns			1
Accidental Firearm			2
Homicide	1	3	18
Medical Causes		7	8
Vehicle Accident	1	10	13
SIDS		4	4
Suffocation		1	4
Suicide		2	2
SUIDS		5	6
Unknown			2
Total	3	34	73

No Abuse / Neglect Findings

Cause of Death	Preventability: Not at All	Possibly	Definitely	Missing
Crush			1	
Dog Bite	1		1	
Drowning	5	13	9	1
Falls		2		
Fire/Burns	1	14	9	
Accidental Firearm	3	1	4	
Homicide	10	11	20	1
Medical Causes	45	32	19	1
Vehicle Accident	22	69	56	1
Poisoning		2	6	1
SIDS	29	25	21	1
Struck	1			
Suffocation	4	8	4	
Suicide	3	11	7	
SUIDS	15	28	13	1
Unknown	5	3	5	
Total	144	219	175	7

APPENDIX D
COUNTY COMPLIANCE WITH REVIEWING ELIGIBLE DEATHS

Reviewable Deaths Reviewed/Eligible Deaths 2002, by County



APPENDIX E
2002 CHILD FATALITY REVIEWS, BY COUNTY, BY AGE GROUPS

Appendix E presents county level data for the Child Fatality Review process in 2002. The data is presented for four age groups (infants less than 1 year old, children from 1 to 4 years of age, children 5 through 14, and teenagers ages 15 through 17). Four numbers are provided for each age group:

Total Deaths: The total number of deaths (all causes) for that age group. This number is based on Georgia death certificate data and only includes deaths to Georgia residents under the age of 18. This does include deaths of Georgia residents that occurred in other states and were reported back to Georgia, but it does not include deaths of out-of-state residents that occurred in Georgia.

Eligible Deaths: The number of SIDS, accidental, or violence-related deaths (eligible deaths) according to the death certificate classifications. Although other deaths due to medical or natural causes may be eligible for review according to OCGA 19-15-3(e), SIDS deaths are explicitly required to be reviewed, and accidental/violence related deaths should be reviewed as "sudden or unexpected deaths." Thus, this number represents a minimum number of deaths that should be reviewed. This is a subset of total deaths (DTH).

Eligible Deaths Reviewed: The number of SIDS, unintentional, or violence related deaths that were reviewed. This number is a measure of how well a county identified and reviewed the minimum number of appropriate deaths. This is a subset of the total "eligible" deaths.

Total Deaths Reviewed: This is the total number of child deaths in 2002 for which a Child Fatality Review Report was submitted. It includes deaths due to medical causes (other than SIDS) in addition to those deaths which were identified as eligible for review. This is based on the county of residence identified from the death certificate.

Appendix E

Child Fatality Reviews, by Death Certificate County of Residence

County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
AGE	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Appling	4	1	1	1	7	1				1	1				1	3	1	1	1	6
Atkinson			1		1			1		1			1		1			1		1
Bacon	3			1	4	1			1	2	1				1	1				1
Baker	1	1		2	4															
Baldwin	10	1		1	12	2				2	2				2	2				2
Banks	1				1															
Barrow	6	2	1	3	12	5	2	1	3	11	3	1	1	3	8	3	1	1	3	8
Bartow	11	2	4	1	18	3	1	2		6	3	1	2		6	4	2	2	1	9
Ben Hill	5	2	1		8		1			1		1			1		1			1
Berrien	4			1	5	2			1	3	2			1	3	4			1	5
Bibb	33	6	4	4	47	5	3	2	4	14	5	3	2	3	13	7	4	2	3	16
Bleckley	2		2		4			1		1			1		1			2		2
Brantley	3			1	4	1			1	2										
Brooks	1	1	2	1	5		1	2	1	4		1	2	1	4		1	2	1	4
Bryan	2		1	2	5	1		1	2	4	1		1	2	4	2		1	2	5
Bulloch	10	2	2	3	17				1	1				1	1				1	1
Burke	5	2		3	10	1	1		3	5		1		3	4		1		3	4
Butts	2				2															
Calhoun	1				1															
Camden	4	1	2	1	8	2	1	1	1	5	2	1	1	1	5	3	1	1	1	6
Candler	2	1	1	1	5				1	1						1				1
Carroll	13			3	16	3			2	5	3			2	5	12			3	15
Catoosa	7	1	1	1	10	2	1	1	1	5	2	1	1	1	5	2	1	1	1	5
Charlton	4	2	1		7	2	2	1		5		1	1		2		1	1		2
Chatham	40	7	4	7	58	6	4	2	5	17	6	4	2	5	17	8	5	4	6	23
Chattahoochee	1			1	2				1	1				1	1				1	1
Chattooga	3				3															
Cherokee	13	1	3	3	20	5		2	3	10	4		2	3	9	6		3	3	12
Clarke	10	1	2	2	15	2	1	1	2	6	2	1	1	2	6	2	1	2	2	7
Clay	1				1															
Clayton	53	9	6	5	73	12	7	2	2	23	12	7	2	2	23	14	6	3	3	26
Clinch			2		2			2		2			2		2			2		2
Cobb	64	8	11	15	98	7	3	7	11	28	7	3	7	11	28	8	3	8	12	31
Coffee	12		2		14	1		1		2	1		1		2	1		1		2
Colquitt	9		1	2	12	1		1	2	4	1		1	2	4	2		1	2	5
Columbia	9		4	1	14	1		4	1	6	1		2	1	4	1		2	1	4
Cook	1				1															
Coweta	3	3	5	1	12		2	1	1	4		2	1	1	4		2	1	1	4

Appendix E
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County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
AGE	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Crawford	1	1	1		3			1		1										
Crisp	3	1		2	6				1	1				1	1		1		2	3
Dade	2			1	3		1		1	2		1		1	2		1	1	1	3
Dawson			1	1	2			1	1	2			1	1	2			1	1	2
Decatur	1			1	2				1	1				1	1		1		1	2
DeKalb	116	13	19	15	163		15	6	11	9	41		11	2	7	8	28		13	3	8	9	33
Dodge	2	2	1	2	7			1	1	1	3			1	1	1	3		1	1	1	3
Dooly		2		1	3			2			2			2			2		2			2
Dougherty	11	3	3	1	18		1	3	1	1	6		1	1	1	1	4		1	1	1	1	4
Douglas	7	1	1	2	11		1			2	3		1			2	3		1			2	3
Early	1	1	2		4				1		1				1		1		1		1		2
Echols	2				2		1				1		1				1		1		1		2
Effingham	5	1		1	7			1			1			1			1			1			1
Elbert	2	1	1		4				1		1				1		1				1		1
Emanuel	3			1	4					1	1					1	1				1	1	2
Evans	1		1		2				1		1				1		1				1		1
Fannin	3				3														1				1
Fayette	6		1	1	8		3				3		3				3		3				3
Floyd	11	3	3	2	19		3	2	2	2	9		3	2	2	2	9		3	3	2	2	10
Forsyth	15	3	4	1	23		3	3	1	1	8		2	3	1	1	7		3	3	1	1	8
Franklin	1	2	1		4																		
Fulton	140	16	15	18	189		20	7	6	15	48		18	7	5	15	45		23	10	9	17	59
Gilmer	7		2		9		2		1		3		2		1		3		2		1		3
Glascock			1		1				1		1				1		1				1		1
Glynn	11	2	3		16		2	1	3		6		2	1	3		6		3	1	3		7
Gordon	9			3	12		4			3	7		3			3	6		4			3	7
Grady	2		1	1	4				1	1	2				1	1	2				1	1	2
Greene	1	1			2								1				1		2	1			3
Gwinnett	82	15	9	12	118		10	11	4	10	35		9	11	4	10	34		13	10	4	10	37
Habersham	5		1	3	9		1		1	3	5		1		1	3	5		2		1	3	6
Hall	25	1	7	2	35		4		6	2	12		4		4	2	10		4		4	3	11
Hancock	3		1		4		1		1		2		1		1		2		1		1		2
Haralson	5		1	2	8		3		1	2	6												
Harris	1		2	2	5				1	2	3				1	2	3				1	2	3

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County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
AGE	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Hart		8	1		9		1			1										
Heard		4		1	5		2		1	3		2		1	3		2		1	3
Henry		17	4	3	4	28		1		3	4	8		1		3	4	8		4	1	3	4	12
Houston		13	3	1	1	18			1	1	1	3			1	1	1	3		2	1	1	1	5
Irwin		1		1	1	3																		
Jackson		5	1	3	2	11				2	2	4			2	2	4			1		2	2	5
Jasper		1			1	2					1	1				1	1					1		1
Jeff Davis		4			1	5		2			1	3		2		1	3			2			1	3
Jefferson		3				3																		
Jenkins		3		4		7		1		4		5		1		4		5		1		4		5
Johnson			1	1		2															1			1
Jones		3			2	5		1			1	2												
Lamar		1				1																		
Lanier																								
Laurens		6	1	1	1	9		1	1		1	3		1	1			2		1	1	1		3
Lee		3	1	1		5		1	1	1		3		1	1	1		3		1	1	1		3
Liberty		22	1	2	2	27		9	1	1	1	12		8	1	1	1	11		8	1	1	2	12
Lincoln		1		1		2																		
Long		1				1		1				1												
Lowndes		19	1	3	2	25		6		1	1	8		6		1	1	8		6	1	2	2	11
Lumpkin		2		1		3				1		1				1		1				1		1
Macon		3			1	4		1			1	2												
Madison		1		3	1	5		1		2	1	4												
Marion		2			1	3					1	1					1	1					1	1
McDuffie		2		1	2	5		1		1	2	4		1		1	2	4		1		1	2	4
McIntosh		1		1	1	3					1	1					1	1					1	1
Meriwether		1	1			2																		
Miller		1				1		1				1		1				1		1				1
Mitchell		4				4														1				1
Monroe		2		2		4				2		2			2			2				2		2
Montgomery																								
Morgan																								
Murray		1	1	1	1	4			1		1	2			1		1	2			1	1	1	3
Muscogee		35	4	4	3	46		8	4	3	2	17		8	4	3	2	17		11	4	3	3	21
Newton		11	1	1		13		6	1			7		5				5		5				5
Oconee		2	3	2		7			2	2		4			2	1		3		1	2	1		4
Oglethorpe					1	1					1	1					1	1					1	1
Paulding		11	3		1	15		3	2		1	6		3	2		1	6		4	2		2	8

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County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
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Peach		5			5		1			1										
Pickens		4	1	2	1	8		1		1	1	3		1		1	1	3		2	1	2	1	6
Pierce		1			1	2					1	1								
Pike		1		2		3				2		2				2				1		2		3
Polk		2		3	1	6				1	1	2				1	1	2				2	1	3
Pulaski			1			1			1			1				1					1			1
Putnam		2	1	2	1	6		1	1	1	1	4		1	1	1	1	4		1	1	1	1	4
Quitman		1				1																		
Rabun		2	1		1	4					1	1					1	1			1		1	2
Randolph		1				1														1				1
Richmond		33	3	8	1	45		3	1	3	1	8		2	1	2	1	6		3	2	3	1	9
Rockdale		1	4		2	7			2		2	4			2		2	4			2		2	4
Schley		1				1																		
Screven		2	1	1	1	5				1		1				1		1			1	1		2
Seminole		2		1		3																		
Spalding		11	1	2	2	16		2			2	4		2			2	4		3	1		2	6
Stephens		2	1	1		4			1	1		2			1	1		2				2		2
Stewart		1				1		1				1												
Sumter		6	2	1		9		1	2			3		1	2			3		1	2			3
Talbot					1	1					1	1												
Taliaferro																								
Tattnall		4	1	2		7		1		2		3		1		2		3		1		2		3
Taylor		1		1		2		1		1		2		1		1		2		1		1		2
Telfair		1			1	2					1	1					1	1					1	1
Terrell																								
Thomas		6	1	1		8		2				2		2				2		2				2
Tift		6	2	3	1	12			1	2		3			1	2		3			1	2		3
Toombs		4		1		5		2		1		3		2		1		3		2		1		3
Towns																								
Treutlen																								
Troup		10	2	1		13		1	1			2		1	1			2		5	2			7
Turner		1			1	2					1	1					1	1					1	1
Twiggs																								
Union																								

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County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
AGE	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Upson		2		1	2	5		1			2	3		1			1		1	
Walker		6	1	2	2	11		1	1	1	2	5		1	1		2	4	1	1	2	4
Walton		6	2	4	1	13		3		1		4		3		1		4	3	1	1	5
Ware		6			2	8		2			2	4		2			2	4	2			3	5
Warren		1				1		1				1		1				1	1			1
Washington		4	1			5		3	1			4		1	1			2	1	1		2
Wayne		4				4		1				1							1			1
Webster																						
Wheeler				1	1	2				1	1	2				1	1	2			1	1	2
White		2	1			3		1				1		1				1	1			1
Whitfield		14		3	4	21		2		1	3	6		2			3	5	2		1	3	6
Wilcox			1			1			1			1											
Wilkes			1			1														1			1
Wilkinson				1	1	2				1	1	2				1	1	2			1	1	2
Worth		1			1	2		1				1		1				1	1			1
Georgia		1188	179	227	201	1795		221	95	127	158	601		190	84	111	143	528		258	104	135	158	655

APPENDIX F
DEFINITIONS OF TERMS AND ABBREVIATIONS USED IN THIS REPORT

A-A
African-American

Child Abuse Protocol Committee
County level representatives from the office of the sheriff, county department of family and children services, office of the district attorney, juvenile court, magistrate court, county board of education, office of the chief of police, office of the chief of police of the largest municipality in county, and office of the coroner or medical examiner. The committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.

Child Fatality Review Committee
County level representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney, law enforcement, and mental health.

Child Fatality Review Report
A standardized form required for collecting data on child fatalities meeting the criteria for review by child fatality review committees.

Eligible Death
Death meeting the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when unattended by a physician, or any manner that is suspicious or unusual.

Form 1
A standardized form required for collecting data on all child fatalities by corners or medical examiners.

Injury
Refers to any force whether it be physical, chemical (poisoning), thermal (fire), or electrical that resulted in death.

Intentional
Refers to the act that resulted in death being one that was deliberate, willful, or planned.

Medical Cause
Refers to death resulting from a natural cause other than SIDS.

Natural Cause
Refers to death resulting from an inherent, existing condition. Natural causes include congenital anomalies, diseases of the nervous system, diseases of the respiratory system, other medical causes and SIDS.

"Other" Race
Refers to those of Asian, Pacific Islander, or Native American origin.

"Other" as Category of Death
Includes deaths from suffocation, choking, poisoning, and falls (unless otherwise indicated).

Perpetrator
Person(s) who committed an act that resulted in the death of a child.

Preventable Death
One in which with retrospective analysis it is determined that a reasonable intervention could have prevented the death. Interventions include medical, educational, social, legal, technological, or psychological.

Reviewed Death
Death which has been reviewed by a local child fatality review committee and a completed Child Fatality Review Report has been submitted to the Georgia Child Fatality Review Panel.

Risk Factor
Refers to persons, things, events, etc. that put an individual at an increased likelihood of dying.

Georgia Child Fatality Review Panel
An appointed body of 16 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data.

Sudden Infant Death Syndrome (SIDS)
Sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. In this report, SIDS is not considered a "medical" cause.

Trend
Refers to changes occurring in the number and distribution of child deaths. In this report, the actual number of deaths for each cause is relatively small for the purpose of statistical analysis, which causes some uncertainty in estimating the risk of death. Therefore, caution is advised in making conclusions based on these year-to-year changes which may only reflect statistical fluctuations.

Unintentional Death
Refers to the act that resulted in death being one that was not deliberate, willful, or planned.